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Disclosure in maternity care contexts: the paradigm case of sexual orientation the paradigm case of sexual orientation

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Disclosure in maternity care contexts: the paradigm case of sexual orientation

the paradigm case of sexual orientation

Elaine Carole Lee

2010

University of Dundee

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DISCLOSURE IN MATERNITY CARE CONTEXTS: THE PARADIGM CASE
OF SEXUAL ORIENTATION

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Degree of Doctor of Philosophy

University of Dundee

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DECLARATION

I declare that I am the author of this doctoral thesis, that all references cited have been consulted by me, that the work presented here has been carried out by me and that it has not been previously accepted for a higher degree.

Elaine Carole Lee

I confirm that the conditions of all relevant Ordinances and Regulations in relation to this doctoral thesis have been fulfilled.

Professor Julie Taylor, supervisor

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Summary

This thesis is a hermeneutic phenomenological study of the concept of disclosure in maternity care contexts using the example of sexual orientation. There is a significant body of literature within psychology and sociology relating to the health and social purposes and consequences of disclosure. There is a further body of outcomes-focused evidence relating to disclosure of sexual orientation in health care. There is, however, little research undertaken into the disclosure of sexual orientation in pregnancy as an action with motive and purpose. This study aimed to address this issue.

The study employed unstructured interviews with eight lesbian mothers, seven of whom were birth mothers and one was a social mother. The hermeneutic method used an iterative process of analysis integrating researcher pre-understandings, thematic analysis of individual interview transcripts and broader analysis of the individual interview data within the total interview data, exploring the parts within the whole. The aim was to identify the shared meaning of disclosure for the participants.

Data analysis resulted in five main themes: being invisible/visible; being upfront; being me; being entitled; being safe. An additional finding was the process of managing negativity through strategies such as rationalisation. Three

encompassing concepts were identified: protection; power; and identity. Two motivations for disclosure were also identified: pro-action and altruism.

The thesis concludes that disclosure is a motivated and purposeful act which has real meaning and consequences. It makes extensive recommendations for midwifery practice including acknowledging the disclosure, understanding the legal complexity, and recognising the lesbian family. Recommendations for policy suggest having explicit and detailed policies that include information about *how* to be inclusive rather than only abstract concepts of inclusion. Recommendations for research include qualitative and quantitative research with midwives about attitudes and knowledge as well as research exploring the role of the social mother in promoting family health outcomes.

Chapter One: Introduction and background

Background to the Study

When I decided to complete a doctorate I wanted to find an aspect of care, essential for good practice as well as relevant to my own philosophy of midwifery. What interested me as a midwife was the idea of women having an aspect of life that was considered important to them but was not obvious to others. How would it feel to have an important aspect of life that would require disclosure but where disclosure might be deemed risky? Pregnancy is replete with episodes of disclosure *per se* and these many episodes combine to create a profile of the woman and an assessment of her individual needs. I became increasingly curious about the effect on the woman's experience of this missing information. Sexual orientation seemed an excellent example of such an issue, particularly in relation to its personal significance for the woman and its potential invisibility to others during pregnancy. It was not the experience of being lesbian, but the experience of the disclosure that formed the basis of my interest. This was also important in its relevance to inclusive midwifery practice, with the woman at its centre, which is the midwifery practice to which I aspire.

The concept of disclosure

Although a more comprehensive analysis of the literature is included in Chapters 2 and 3, I have summarised the main points here in order to provide the context

for this doctoral study. Disclosure is a complex concept which has a number of related aspects that affect the way it is undertaken (if it is undertaken at all). The word itself has a range of connotations, but is often seen as being closely related to confession because this is a context in which the word is used frequently: for example, disclosure by government ministers of inappropriate expenses claims. In addition, it is used to indicate transparency and this is particularly true in relation to the financial services. The extent to which disclosure might be considered a neutral act depends on the context within which it takes place. However, for the purposes of this doctoral study it has been necessary to clarify disclosure's significance in health care, and its importance to physical and psychological health outcomes. This situates disclosure in a potentially more positive context in that it is more about the sharing of information than the confessing of something hidden. It was anticipated at the start of the doctoral study that outcomes from disclosure would be potentially negative because disclosure of minority sexual orientation can be met with a negative response. Fear of negativity was always likely to be part of the experiences of the participants.

The potential for disclosure to influence, positively, the woman's experiences and pregnancy outcomes is also important in relation to this study. The benefits of disclosure are discussed in this section so that the clinical implications are evident. Although sexual orientation is not medically significant, in that it does not affect the pregnancy, it is clinically significant because it has an impact on

certain aspects of the pregnancy experience such as support in pregnancy and labour, family structure, relevance of advice and a range of other physical and psychosocial factors.

Disclosure, as a factor in the maintenance of health, is developing a growing body of evidence within psychology and this is discussed in the literature review in Chapters Two and Three. Jourard (1971a) was one of the first psychologists to develop a theory of the importance of disclosure as an activity in itself. Within the experiments he undertook, the focus was on the psychological consequences of disclosure rather than the information disclosed (Jourard 1971a). These consequences were found generally to be positive. Those factors which inhibit or promote disclosure were also explored, and it was found that an important promoter of disclosure was disclosure from the other person. This reciprocal disclosure meant that individuals were much more likely to disclose to people who disclosed to them, although admittedly the research did not address disclosure where a power relationship might exist. The relationship between health professional and service user could be seen as such an imbalance of power. The necessarily personal nature of maternity history-taking has implications for midwifery practice where midwives might consider the issue of reciprocity to be an unnecessary intrusion into their personal lives. However, reciprocal disclosure need not mean disclosure of the same types of personal information. Instead it might mean the midwife demonstrating a level of

disclosure that indicates a willingness to engage with the woman at a personal level.

Once the importance of disclosure was demonstrated through Jourard's research, further work was undertaken to assess the value of disclosure as a form of treatment, otherwise known as experimental (or emotional) disclosure (Pennebaker and Beall 1986). Experimental disclosure involves the systematic writing down, over a fixed number of sessions, those events experienced by individuals as significant or traumatic. These disclosures are not analysed or read by the therapist. This has been shown to accelerate the process of coming to terms with events which involve psychological or physical trauma (Pennebaker et al. 1990). Importantly, the effects of disclosure can be physical with an improvement in health status demonstrated although the reasons for this remain unclear (Frattaroli 2006). This does not mean that lesbian motherhood is being considered a traumatic event, but that disclosure itself has physical and psychological benefits. That said, in some of the research literature, the disclosure of sexual orientation was deemed by the participants to be the traumatic event about which they chose to write (Greenberg and Stone 1992).

Disclosure has also been shown to have other links with physical health outcomes, although this has to be balanced with the negative effects of non-disclosure rather than simply the positive effects of disclosure. There is some evidence that closeted behaviour can exacerbate disease processes (Cole et al.

1996) and that emotional disclosure can stabilise it (Wetherell et al. 2005). The conclusions that can be drawn about the effect of the disclosure are largely speculative in both these cases. For example, Wetherell et al. (2005) noted a significant positive trend in both physical and psychological outcomes for the disclosure group but determined that this was due to the deterioration within the control group rather than improvement in the intervention group. For Cole et al. (1996) the issue related to the negative behaviours of closeted individuals in not seeking help rather than the positive effects of disclosure per se. However, any positive effect, even if it is the stabilisation rather than the diminution of disease, should be exploited.

Disclosure can take a number of different forms, including that of information exchange. Indeed this is the most common form in health care. Disclosure comes into its own in the context of the clinical history and forms the basis of decision making (Porter 2005; Bugge et al. 2006). The disclosure of information takes the form of a response to questioning which is clinically driven. The questions asked relate to the pieces of the jigsaw that the clinician believes necessary to assess the needs of the individual, and to some extent relies on assumptions about what is relevant and what is not (Röndahl et al. 2006). Of course the clinical significance of certain information will indeed be relevant in the assessment of the individual. This is as true in midwifery as it is in nursing and other health related disciplines. Previous pregnancies, existing medical disorders and health behaviours all have a potential impact on a pregnancy.

However, these are, as it were, the clinically derived 'known unknowns'. They constitute required knowledge for optimal care. Midwifery is also underpinned by a philosophy of individualised care with woman-centredness being an imperative for the profession (Royal College of Midwives 2001). This is discussed in the next section. However, proclaiming a woman-centred philosophy of care would suggest a woman-centred approach to information exchange but this is not the case.

Woman-centred care

A final aspect of the background for this doctoral study is the concept of woman-centred care. This is a key concept in midwifery and underpins professional philosophies and standards (Nursing & Midwifery Council 2009) and strategic policy (particularly in the United Kingdom but also in the United States, Australia and New Zealand among other countries) (Royal College of Midwives 2001; Scottish Executive Health Department 2001; Leap 2009). Indeed, it has been the premise of maternity care since *Changing Childbirth* was published in 1993 with its mantra of *choice, continuity and control* (Department of Health 1993). It is based on the idea that midwifery care should be targeted to the individual needs of the individual woman. Presumptions and generalisations should be avoided within this model, since all women are different. The aim of midwifery care is to help the woman to have the best experience possible based on the woman's own ideas of what is best for her (Thorstensen 2000).

Leap (2000) states that *“women centred care implies that midwifery:*

- *Focuses on the woman’s individual needs, aspirations and expectations, rather than the needs of the institution or professionals*
- *Recognizes the need for women to have choice, control and continuity from a known caregiver or caregivers*
- *Encompasses the needs of the baby, the woman’s family and other people important to the woman, as defined and negotiated by the woman herself*
- *Follows the woman across the interface of community and acute settings*
- *Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations*
- *Recognizes the woman’s expertise in decision making.” (cited in Leap 2009 p.12).*

All of the discussion within this study makes reference to the concept of woman-centred care. It is very similar to the concept of individualised, or holistic, care which underpins the systematic approach to care within professions such as nursing. It is part of the concept of informed decision making and choice. Woman-centred care is both an expectation (by women) and an aspiration (within midwifery practice), but it is subject to variability and organisational pressure which is ironic given the way that it informs government policy and professional rhetoric.

If history-taking is representative of clinically focused information, what about those aspects of a woman’s life that she may consider relevant but which are

invisible in maternity care in terms of their perceived *clinical* relevance? How important are the individually-derived aspects of pregnant women's lives which do not appear to have a basis in clinical assessment as it is generally understood? Does their disclosure or withholding affect women's experience of pregnancy? If they do, how can midwives facilitate disclosure of these individual factors, the details of which she cannot predict? These are all questions that are addressed in this thesis in the context of the lesbian mother, albeit only in relation to disclosure of information. The lesbian mother as the exemplar of this invisible perspective makes the answers to these questions at least partially transferable across contexts.

Sexual orientation as the paradigm case

In the 1950s, Kinsey undertook the first detailed exploration of the prevalence of homosexuality (along the spectrum of sexual behaviours) in the general population, concluding that approximately 10% of the population were gay men or lesbian women (Kinsey 1948; Kinsey 1953). Using this figure would mean that around 6 million people in the UK would be considered homosexual. However, any reliable assessment of the true prevalence is highly problematic, and prevalence figures vary significantly. More recent figures published by the UK Treasury in 2005, which were developed in the context of the assessment of the probable financial implications of the Civil Partnership Act (2004), suggest that prevalence is closer to 6%. Given the current population in the UK of 61.4 million this percentage represents 3,684,000 people (Office for National Statistics 2008).

There are no current figures in relation to the prevalence of lesbian pregnancy however using some very rough calculations it is possible to approximate this figure. If 50% of the overall number of gay people in the UK is female this results in a very approximate figure of 1,842,000 women. Given the varying figures of lesbian and bisexual women this number might be reduced but is a working figure. UK population figures give a total of 12,173,600 women of reproductive age, out of a total of 31,231,800 women. This suggests there are approximately three quarters of a million lesbian women in the UK who *could* consider pregnancy. No figures are currently collected for lesbian mothers in the UK so I have used figures from the United States to offer a further approximation. Riskind and Patterson's (2010) findings suggest that approximately one third of childless lesbian women express a desire and intention to have children. This results in a final approximate total of 250,000 lesbian women in the UK who could potentially become mothers. Obviously this provides no indication of the actual number of pregnancies for lesbian women each year but represents a sizeable population.

Whatever the figure, this population group is largely invisible, in healthcare and in everyday life, because this form of minority status is not represented by visible attributes in the individual (Wilton and Kaufmann 2001). In maternity care there is a tendency to assume that if a woman is pregnant then she must be heterosexual. Because human reproduction depends on the joining of male and female DNA it is easy to assume this has been achieved through heterosexual

intercourse. Maternity care is organised and delivered largely on this basis and this means that documentation, organisation and therapeutic approaches are all 'heterocentric'. This results in institutional heterosexism, derived from assumptions made about relationships and pregnancy.

A limited amount of empirical work has been undertaken into the experiences or needs of lesbian women in pregnancy. Wilton and Kaufmann (2001) remains the only significant research study undertaken within the UK. There is, however, a growing body of literature that relates to the more general healthcare experiences of gay men and lesbian women, either as patients or employees (Taylor 1999; Cant 2005; Ward and Winstanley 2005).

Recent research in New Zealand (Neville and Henrickson 2006) has highlighted the importance of disclosure of sexual orientation in primary healthcare, concluding that nurses use gendered language and documentation which excludes those from lesbian, gay or bisexual client groups. The study concludes that statistically more women than men report that their health care providers always presumed them to be heterosexual. So there is some evidence that health care practitioners presume heterosexuality, and the context of health care might well have an impact on this. Where there is a pregnancy there is an additional signifier of heterosexuality. Lesbians, gay men, bisexuals and transgender people (collectively known as LGBT), have the same range of health needs as all people – asthma, cardiovascular diseases, breast cancer etc. – but

within research, and within the understanding of health care practitioners, their needs tend to be compartmentalised within the clinical speciality of sexual health; being identified with sexually transmitted infections because they are identified by their sexuality. This has tended to make LGBT people invisible in mainstream health care although they will access healthcare across the speciality spectrum.

The focus of the study

The aim of this research was to explore lesbian women's experiences of disclosing their sexual orientation to healthcare professionals when pregnant, and the effects this had on their experiences of pregnancy and maternity care. The research was undertaken using an underlying feminist philosophy with the aim of making an invisible group of women more visible in maternity care settings; to take the heterosexist assumptions of pregnancy and maternity care and to look at them from a different perspective. This different perspective is one that is hidden because the client group is frequently hidden (Salmon and Hall 1999). A long term research aim for me is to make explicit the experiences and needs of this group of women and so to influence maternity care in ways that help to meet these needs. However, the first steps must be taken in order to identify the key issues for lesbian women in terms of disclosure and to explore the extent to which these issues have a qualitative impact on the women's overall experiences of having a baby. If viewed with the Medical Research Council's framework for complex interventions (Medical Research Council 2008)

this study falls within the **Development** element identifying the evidence base and identifying and developing theory. Comprehensively reviewing the literature was a fundamental part of this, and will be discussed, but the study itself was part of adding to the body of background knowledge. This early stage of research is important where the appropriate intervention itself is not yet known.

It was hoped that this study would enable lesbian women to talk in their own terms and to choose the aspects of disclosing sexual orientation that were important to them during their pregnancy. There is enough research literature relating to “coming out” to know that this act has important psychological and experiential implications for gay men and women within healthcare, and all other aspects of life (Taylor 1999; Markowe 2002; Gill et al. 2005). But this context is unique in that the process of pregnancy presumes heterosexuality and coming out is required for the lesbian who wants to be acknowledged as such. The issue is also clinically important because of the impact that unknown or incomplete family history can have on the care given in pregnancy. Disclosure must be viewed in the context of history-taking which is seen as having increasing importance for the quality of maternity care received by women.

Managing the labels – the language of politics

Before discussing the review of the literature I felt it would be useful to reflect on some of the difficulties I encountered with the language of the study. It is also

helpful to discuss how the issue of language in a politically sensitive PhD was a serious impediment at each stage of the process. Attempting to say what I meant was a potential minefield when the language was laden with political ambiguity and this affected the way that I disseminated findings at different times in the process.

Within the context set out in this introduction, the issues raised by language will be explored in order to make explicit some of the decision-making in relation to chosen language. I suspect that part of the reason for experiencing problems with language is the outsider perspective that I inhabit in this study. As a heterosexual woman I cannot lay claim to the insider understanding of the controversy of language but I have always aimed to produce a body of work that avoids assumptions, is emancipatory in its aspiration and which promotes a high quality experience for lesbian women and their partners.

The minefield of language

Early on in the process of this doctoral study, I was criticised for making assumptions about lesbian women, either through drafts of written work or through attempts to publish the literature review, and was pointed in the direction of particular literature. The purpose of this was to direct me towards literature that had already addressed the issue of lesbian motherhood. I explored that literature and felt, in part, vindicated by what I found. I have used the examples of this literature for the purposes of this reflection. In doing this I

have identified the key concepts and attempted to explain the way in which problems arose.

Much of the language used by those publishing in relation to the LGBT population is commonly used language. However, the meanings are often ambiguous or politically contentious, making it difficult to express ideas clearly. The first example of the 'odd' way that lesbian mothers are presented in the literature comes from Jackson (2003), a midwifery academic, who attempts to describe the variety of ways in which lesbian women become mothers. She writes:

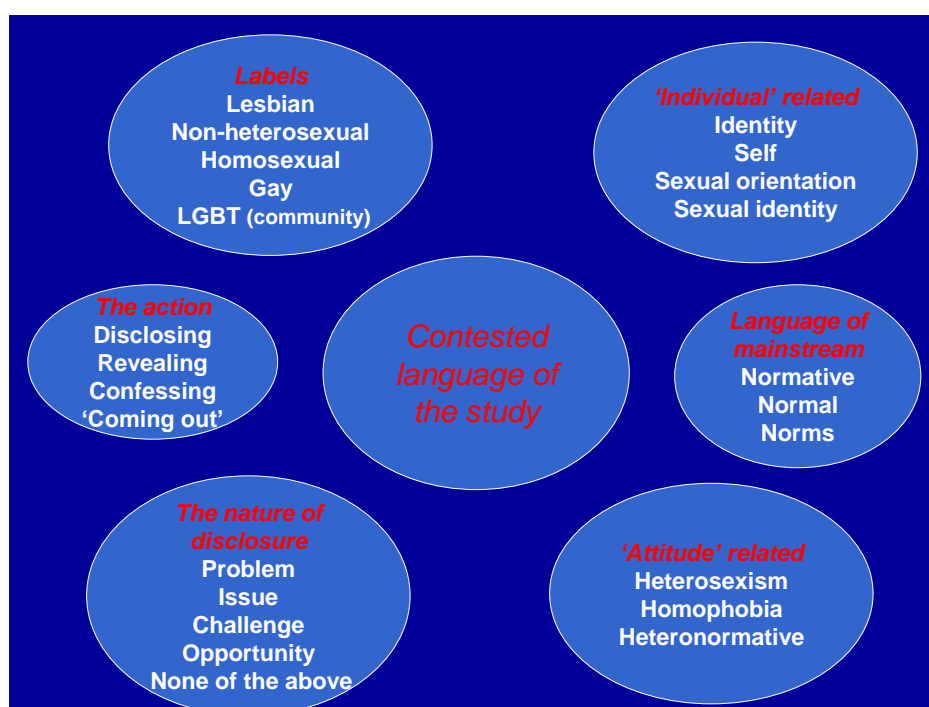
"Some seek out male friends to impregnate them, others may undergo a one night stand to procure the required bodily fluid. Others who may be more conscious of the possible health risks involved in the first two approaches mentioned, may pay privately for artificial insemination. Others still may have become lesbians while pregnant or after having children."(p.434)

While all of these might in some sense be true, the words chosen and the way they are used seem somehow to separate further this group of women from the mainstream. They are either viewed as passive recipients of sperm, or they are acquiring it through deception and in doing so are behaving irresponsibly. The last statement, in particular, appears to confirm the widely held belief that being

gay is a lifestyle choice by using the word 'become' rather than, for example, acknowledge or realise or something more intrinsic. I found it ironic that the literature to which I was being referred as examples of good practice had also fallen into the trap of inadvertently misrepresenting lesbian women.

The language trap has been effectively laid through years of political change, and the growing move towards equality for those in the LGBT community. This has resulted from changes in acceptability of particular words as well as ambiguity in meaning and lack of understanding in relation to key words and phrases. These issues have been presented diagrammatically in Figure 1 and will be addressed next. A discussion of the issue of labels is provided later but the diagram is presented here to illustrate the complexity of language through categorising it in the balloons.

Figure 1: The contested vocabulary of the thesis



Naming sexual orientation: finding a 'label'

Early on I decided to use the word *lesbian* to identify the women comprising the study population. The reason that I did this was because I felt it was essential to be able to describe in words what I was actually doing within this study. I had to provide some kind of descriptive 'label' for the women I hoped to recruit and whose narratives I hoped to engage with as part of the research. This was necessary for my inclusion criteria and for my ethics application. However, the language was still problematic and there are several ways to approach it.

Lesbian is a word that has a clear enough meaning. It is commonly understood and widely used. However, it is not universally liked or chosen by lesbian women.

Lesbian has negative connotations within the heterosexual population and is often used as an insult. Cronin (2004), a sociologist contributing to a set of feminist writings in maternity care, relates a conversation she had with female health professionals during a workshop on lesbian health. One woman described how she was called a lesbian as a child because she held her friend's hand. She recalls the frustration she felt because no one would tell her what it meant. The negative connotation for her was based on personal experience and a memory of pain. In undertaking this doctoral study I have been attempting to describe the experiences of lesbian women in a way that represents *their* reality and *their* understandings but also in a way that does not perpetuate negative meanings among those to whom I hope to disseminate the findings. The fact that the

language and the experiences can be viewed in negative terms makes this harder.

Midwifery literature tends to use the word *lesbian* in an unproblematic way and perhaps it is not something I should have worried about too much. But there are other ways to look at this or other labels to apply. Cronin (2004) uses the terms *non-heterosexual* as a way to avoid a standard label. Unfortunately, this brings with it another set of problems. The primary problem is that the woman is forced to identify her own sexual orientation in relation to the majority sexual orientation.

Another possibility is one that Cronin (2004) uses almost interchangeably with non-heterosexual; the term *women who self-identify as lesbian*. This had its attractions. I liked the fact that this relates everything to the woman and the way she chooses to describe herself, but it does not change the issues already discussed because the woman has to identify herself in the terms defined elsewhere, in other words as being different from the heterosexual norm. However, the issue of language is only important if the attempt at inclusive research leads to the objectification of the group of women involved.

I have felt strongly throughout this study that I did not want language to become an issue of political correctness and finding bland language that does not really say anything in an attempt not to offend. I did not want to use language which

was seen as having a political purpose. I did not have an agenda beyond enhancing the experiences of women having their babies, but a simple choice of word can have a significant impact on the meanings given to the situation. It was not until I presented my language quandary at a national LGBT seminar that I started to become more comfortable with my choices. The discussion generated, suggested that it was attitude rather than language that was the core of problems relating to sexual orientation and that I should worry about it less (Lee 2008).

I assumed that this issue would to some extent resolve itself as the study went on because I believed that women would use their own language and choose the label that they recognised for themselves. With hindsight I do not think this was the case. Only one participant appeared comfortable to choose her own words and she described herself as *queer*. The other participants used the word lesbian, partly I suspect because it was the word that I used. Listening to their interviews and the slight hesitation when they use the word lesbian I cannot help but ask myself if this was my choice, not theirs. I could have asked the women to tell me how they would like to be identified but at the time I felt unable to do that for fear of making this more of an issue that it needed to be.

Conclusions

As can be seen from Figure 1 there are numerous other problem areas within this subject. Each of them has their own questions relating to meaning and appropriateness and one solution to this would have been to produce a glossary of terms giving the words and meanings that I had decided to use. However, this is not a particularly inclusive or sensitive way to approach the issue in a study that is underpinned by feminism and whose aspiration is to increase understanding of lesbian women's experiences of pregnancy. So the diagram contains the lexicon that I used for the purposes of the study.

Next steps

In this chapter I have aimed to provide some background to the doctoral study and to present some of my own journey to this point. I have aimed to provide the context within which I approached the subject of the study and to set the scene for the discussion that follows.

In Chapter Two, I explore the literature in relation to disclosure as a concept, the different ways that it is used and understood, how it contributes to health outcomes, and also the way it relates to identity formation and expression. This Chapter also organises the analysis within the structure of a concept analysis.

In Chapter Three the discussion becomes more specifically related to disclosure and maternity care, including the attempts made through policy to address issues of diversity while being limited in their success. The use of standard patient information designed to ensure the taking of a comprehensive client history and how these have both addressed and contributed to heteronormativity in maternity care will also be explored.

In Chapter Four, I explain Hermeneutic Phenomenology, my chosen methodology, and in Chapter Five develop this further to discuss the associated method, including sampling, the process of undertaking dialogues, a discussion of the engagement with the dialogues and a number of methodological issues.

Chapter Six is a presentation of the pre-understandings prior to the interviews and initial understandings following them. This is an important aspect of the methodology and provides the start of the hermeneutic circle and a reference point for the iterative engagement with the interview data.

This is followed by a more in depth analysis of the interviews in Chapter Seven. The findings from the study are presented, along with the quotes that exemplify them, in keeping with the research method. An analysis of the way that the women interpreted negative experiences is also presented in this chapter.

In Chapter Eight, I discuss the findings through the concepts that encompass them. The triad of concepts that address the research aim are discussed with reference to literature and to theory. Important issues that support a position contradictory to that of mainstream maternity care are identified and explicated in this chapter.

In Chapter Nine, some conclusions and recommendations for practice, policy, education and future research are offered. In this chapter there is also a discussion of the limitations of the study and this helps provide a context within which the conclusions are offered.

Chapter Two: Understanding Disclosure – Concepts, Definitions and Associations

Introduction

The concept which underlies this PhD study is that of *disclosure*. This is a broad concept with a range of connotations which have been explored for the purposes of this thesis. In this section I will explore some of the underlying concepts, definitions and associations of disclosure introduced in Chapter One, and attempt to deconstruct the way it is used in various settings, i.e. its contextual applications. Concepts of confession, coming out¹, informing, story telling, revealing and ‘being’ are explored, with particular reference to sexuality and sexual orientation. The impact that coming out can have on an individual, their health and sense of who they are will also be discussed in this chapter.

In common with many words in the English language, *disclosure* has a number of meanings and these meanings have a variety of affective connotations. Arguably its use can be said to be negative, positive or neutral. Although philosophically and conceptually complex, disclosure is fundamentally the act of revealing, uncovering or bringing to light something which is hidden, and often something

¹ Coming out is seen as an ongoing process which starts with the initial coming out to self. In this thesis the terms refers almost exclusively to those instances where the women come out to another in a specific context rather than referring to the first instance of coming out as lesbian.

which is significant to the individual (McDonald 2008). Disclosure means in some way exposing information, or aspects of individuals, which were previously unseen or unknown by others. It may be, but is not necessarily, about the act of telling because disclosure is not limited in its form – it can be verbal or non verbal. Disclosure is simply about making something obvious and revealing its existence. This definition of exposure, however, relates to revealing what is hidden, and could involve revealing something that was hidden for a particular reason (McDonald 2008). Because of this, the term is not without its definitional challenges and the process of disclosing is not without consequences, or even costs, for the individual.

Reasons to disclose aspects of ourselves as individuals are many and varied. The patient journey in healthcare, for example, is signposted with numerous junctions at which disclosure is required or requested. The primary example of this is history-taking, either during a medical consultation, the first interaction with a health professional, or through exchanges with such professionals during episodes of care. Disclosures may range from describing the quality of a night's sleep to revealing personal information not normally revealed to strangers.

Maternity care is an example of healthcare where disclosure forms the basis of care planning, with the booking visit being the primary episode. Along with the associated disclosure episodes in the pregnant woman's journey, there are assumptions about pregnant women within which these episodes of disclosure

are contextualised. For women from invisible minority groups, such as lesbian women accessing maternity care, these assumptions and contexts of disclosure are potentially skewed. The importance of disclosure for women from invisible minorities can, to some extent, be assumed. Groups that derive minority status from the unobvious, and therefore invisible, must undertake the process of revealing the fact of their 'difference' in order for this to be seen. So to disclose is to be made visible. However, being part of an invisible minority suggests that, without disclosure, the individual appears to 'belong' to the dominant social group. To stand up and say 'actually I'm not one of you' is, potentially, to take a significant risk. All of these issues were dominant within the interviews undertaken within this doctoral thesis and will be discussed in Chapters Six and Seven.

The literature search

In order to explore the literature in relation to disclosure an extensive search was undertaken. *Disclosure* was used as a keyword within a range of health and social science databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, The British Nursing Index, Applied Social Sciences Index and Abstracts (ASSIA), the University of Dundee Library Catalogue, Google Scholar and IBSS. This resulted in a wide range of results, including results from psychology, health and financial services. All literature relating to financial disclosure and transparency was discarded because it was organisational in nature and embedded in financial services legislation. Disclosure in these

circumstances is not open to choice as failure to disclose would mean breaking the law.

As this was an initial exploration of the literature, no date restriction was used. This was important in highlighting the early research in psychology relating to the psychological health benefits of disclosure.

Further searches were undertaken in the same databases using the keywords *gay AND healthcare, homosexual AND healthcare, lesbian mothers, lesbians AND pregnancy, lesbians AND maternity care and same sex parents*. A date range initially of 1995 – 2005 was used which represented the ten year period prior to the start of the study. Both this search and the searches in relation to disclosure were repeated throughout the study and the subject topic alerts were set within databases in relation to *lesbian mothers, same sex, Gadamer, hermeneutic phenomenology and disclosure* to ensure that the literature remained current. The discussion in relation to disclosure in health care environments and the experiences of lesbian mothers are presented in Chapter Three. The following discussion in this chapter aims to capture the breadth of meaning in relation to disclosure in order to identify it as a complex concept.

Disclosure as a concept

Disclosure is a concept that has been extensively explored in health care and psychology literature in recent years (Cole et al. 1996; Griffith and Hebl 2002; Prior et al. 2003). Cole et al. (1996) undertook research exploring the impact of psychological inhibition on 222 HIV seronegative gay men. Psychological inhibition in this context was defined by 'a failure to publicly express any significant private experience' (p.243). In this specific case 'private experience' referred to sexual orientation, and in particular the concealment of sexual orientation with its subsequent inhibition of overt markers, such as hand holding with a partner in public. The study tested the hypothesis that psychological inhibition would have a negative effect on health outcomes for this group of men. The study findings indicated a significant increase in ill health for those men who concealed their sexual orientation. Other factors such as age and ethnicity were excluded as being influential in the outcome. This study was important because it demonstrated a link between physical health and disclosure although the causative factors were unclear. The results did, however, suggest that the causes were disclosure-related, and not the result of other psychosocial or behavioural factors (Cole et al. 1996), extending the theoretical basis for improved health outcomes and disclosure.

Griffiths and Hebl (2002) explored the issue of 'coming out' in work settings. This study's population comprised 220 gay men and 159 lesbian women. The study tested six hypotheses in relation to factors which influence decisions to come out

to work colleagues, in the context of fear of rejection or stigmatisation. Although the presence of support structures in the workplace and the centrality of gay and lesbian identity were not associated with increased levels of disclosure, it was found that a perception that the environment is supportive of gay and lesbian employees encourages disclosure. This is important because it is suggestive that formal structures to promote diversity alone are less trusted than a 'felt' or perceived sense that the workplace is supportive. While a central identity as gay or lesbian did not increase disclosure, the level of acceptance of sexual orientation in the individual was indicative of likelihood to disclose. This indicates that how the individual person feels about themselves as a gay person is important in the decision to disclose. Griffith and Hebl (2002) were unable to support the hypothesis that disclosure of sexual orientation in the workplace would lead to increased job satisfaction or decreased anxiety. The study was indicative that disclosure of sexual orientation can cause anxiety, regardless of the perception that the disclosure will be positively received.

Taking the issue of stigma further, Cunningham et al. (2009) explored the impact of stigma (external) and shame (internal) on disclosure of sexually transmitted infections to health professionals, indicating that, particularly in women, stigma was more likely to influence attitudes to disclosure than was shame. The perceived reaction of others to the disclosure was more strongly influenced by the individual's beliefs about stigma than their own attitudes to having an STI. All of the participants in this study had previous experience of STI treatment and,

therefore, could draw on this experience when assessing likely outcomes of disclosure.

However, although the findings reached the level of statistical significance, there is no analysis of the impact of the sample demographic, although it is acknowledged as a limitation. The participants in the study were all African-American and were all living within the same area of urban deprivation with high STI rates. The impact of these factors on perceptions of stigma and shame, as well as attitudes to disclosing to health professionals, can only be guessed at but certainly limit the generalisability of the study findings. The study does, however, support the findings in other studies that perception of outcomes will influence decisions to disclose.

In contrast, Prior et al. (2003) suggest that disclosure (in this case, of emotional problems) was not necessarily influenced by fear of outcomes such as rejection or stigmatisation. They suggest, instead, that disclosure in health care settings can be influenced by the lay person's understanding of their condition, or even whether they have a condition as such. This implies that lay people perceive the relevance of disclosure differently to health professionals. Prior et al. (2003) also intimate that there is a conflict between the taxonomic classification of emotional problems of health professionals and lay people. The study was limited by a fairly small and localised sample size; however the aim was to explore further the role of stigma in the disclosure of mental illness. There is a

belief within the mental health professions that disclosure of mental illness is essential for diagnosis, classification and treatment but that individuals avoid disclosure through fear of stigmatisation. Prior et al. (2003) argue that the focus on stigma has limited the exploration of reasons for non-disclosure, and that other factors could also influence disclosure. The study findings suggest that lay people do not necessarily disclose mental illness because they do not work within the same classifications as health professions. Specifically, they do not recognise that they have an illness to disclose because they view health in terms of *physical* rather than psychological wellbeing. In order to fear stigma, the lay person would have to recognise that they had a condition that might be stigmatised.

The findings from Prior et al. (2003) are supported more recently by a small scale qualitative study exploring the interpretations of safety in maternity care (Smythe, 2010). Using hermeneutic phenomenology to interpret concepts of safety in the stories of women, Smythe (2010) suggests that disclosure of safety fears to health professionals by women is complicated by the conflicting understanding of 'safety'. Failure to disclose a significant feeding problem in an infant, for example, was perceived by midwives as neglect but for the woman it was a matter of interpretation of the safety issues from a lay perspective. Disclosure was dependent on the woman recognising that there was an issue of safety in the infant, but this safety was classified through clinical definitions. These were definitions of which the women did not necessarily have knowledge.

These studies help illustrate that disclosure is an important concept with important outcomes but a concept that is complex in its triggers and consequences. The rest of this chapter will explore the concept of disclosure more widely.

Performance and disclosure

The following exploration of disclosure is not limited to verbal disclosure, and this enables the interpretation of disclosure to be broad, including non-verbal disclosure. This relates very much to being 'ourselves' or behaving in a way that is consistent and congruent with whom we perceive ourselves to be. This type of disclosure is not self conscious, but is, instead, a natural state of being that allows others to us (Brown 1998). In maternity care a significant majority of women will be in 'stable' or existing heterosexual relationships. Pregnancy is usually the result of consensual heterosexual intercourse and sits comfortably in the heterosexist and moral norms of most societies. For this reason it is something that the couple do together, although only one can be pregnant.

The way that women interact with their partners, and the extent to which they are free to do so, is an important part of the experience of maternity care (Dibley 2009). Although Dibley's (2009) study was a small scale qualitative exploration of lesbian parents' experiences of having a sick child, her participants discussed the

importance of being a couple and both being treated as the parents of the child. This was important in relation to involving them within the care their child received and the related decision-making.

Having a baby is often described as a rite of passage (Davis-Floyd 2004) and also a significant process in the life of any relationship. In a heterosexual relationship the expression of intimacy is an accepted, and indeed expected, part of becoming a family. In labour in particular, couples may display a closeness that 'performs' their relationship in a heteronormative way but if the couple are lesbian then this performance is less possible. The performance itself becomes the disclosure so the degree to which the woman trusts those around her determines whether or not this performance takes place (Ward and Winstanley 2005). Ward and Winstanley (2005) that this type of performance disclosure is important for forms of diversity where invisibility is possible. This would include sexual orientation but not race, for example. Disclosure becomes important because there is a lack of 'fit' between the individual and whom they see themselves as being (their subjectivity) and the subject position available to them in the context within which they find themselves. In maternity care this subject position is that of a pregnant woman and 'pregnant woman' is viewed with certain assumptions; heterosexuality being ones of these. Butler (1990) argues that the disclosure creates a new subject position that is more congruent with the subjectivity of the individual. Being able to relax and 'perform' oneself

requires disclosure and a safe environment in which to be who you are (Williams-Barnard et al. 2001).

The performance of self is well documented (Goffman 1963) and the 'acting out' of social norms, for example representations of gender, is something that is increasingly revealed within the literature on 'coming out' (Salih and Butler 2004). Performativity as a concept can be useful when describing the processes undertaken by individuals when they play a part – either that of the role they think they should play or that role in which they wish to be viewed in order to disclose (Butler 1990). But it is a complex concept situated within a post-modern ethos that strives to challenge established ways of thinking. For this reason its inclusion here presents difficulties in interpretation. Indeed, where performativity is used as a theoretical framework for the interpretation of behaviour, it is not always clear that Butler's concept is fully understood and how it is being applied (Ward and Winstanley 2005). In this thesis it is used to describe the activities undertaken by lesbian mothers that signal partnership or motherhood.

'Coming out'

This thesis does not extensively explore the concept of 'coming out' since most of the literature in relation to this relates to the first episode of coming out, almost as an acknowledgement of sexual orientation by the individual, *to him or*

herself, through disclosing to significant others such as parents. However, disclosure in the context of health care can be viewed as an episode of the ongoing process of 'coming out' since it relates to an acknowledgement by the woman of her minority sexual orientation within an individually significant context. The woman may do this for a number of reasons and the degree to which the disclosure results in a positive outcome depends on the circumstances, the attitude of the person to whom the woman discloses, and the extent to which the woman herself accepts and internalises her own sexuality as something positive (Kus 1985; Mulligan and Heath 2007). Disclosure is also affected by the anticipated outcome and if a negative outcome is anticipated, disclosure might well be withheld (Jourard 1971a).

Sexual orientation is often viewed as a signifier of self (Fraser 1999; Mulligan and Heath 2007) and as such its disclosure forms a vital element of the relationship development between the woman and her midwife. In order for the midwife to be 'with woman', the 'woman' must exist, and she must exist not just as one of many but as an individual who is unique and who is whole.

The nature of coming out

Coming out has been explored widely in the literature – in health care (Taylor 1999; Cant 2005), in the work place (Ward and Winstanley 2005) and in the family (Valentine et al. 2005).

In an exploration of models of identity formation, Taylor (1999) offers an analysis of the way that 'coming out' leads to identity formation as a transitional process. She argues that the historically negative connotations applied to labels indicating sexual minority leads to reluctance by those *from* sexual minorities either to identify as such or to disclose to others. The context of her discussion is disclosure of minority sexual status in health care situations. Drawing on studies exploring the link between disclosure and physical health (Cole et al. 1996), Taylor (1999) argues that the link lies in the failure by health professionals to provide appropriate care in the absence of disclosure because it is not possible to provide a holistic approach in these circumstances. More importantly, Taylor (1999) argues that the process of disclosure in terms of 'coming out' is not linear. Nor does it go in only one direction. People from sexual minorities will disclose and conceal depending on the circumstances (for example perceived risk) and so health professionals need to ensure that conditions for disclosure are optimal if they aspire to provide holistic care.

Cant's (2005) empirical, qualitative exploration of the relationship between disclosure and the client/carer relationship, specifically in relation to general practice, suggests that 'coming out' alters the relationship between the discloser and the person to whom they disclose. Although relatively small scale in nature, with 38 service users and 12 healthcare managers, the research aimed, through purposive sampling, to reproduce the diversity of the population from which it was drawn. Cant's (2005) study indicated that a failure by health professionals to

engage with the disclosure would often lead to the individual looking for a new general practitioner. The importance of communication and appropriate response to disclosure was seen as key because failure to recognise the significance of the disclosure potentially led to a subsequent failure to offer appropriate health services. 'Knowing' the client therefore can be seen as an important part of providing the right care (Cant 2005). In the context of increasing pressures to improve patient involvement in decisions about care and treatment, Cant's (2005) conclusions are congruent with moves to expand conceptual frameworks around user involvement (Entwistle and Watt 2006).

Ward and Winstanley (2005) explored the experience of being gay at work, although they state that 'coming out' became the primary issue raised in their interviews. They argue that in the literature relating to management and work, 'forms of diversity where invisibility is possible' (p.448) are far less extensively researched than visible forms of diversity such as sex and race. However, coming out at work affects the way that the individual 'performs' their identity. They identified three main themes: undisclosed subjectivity; performative act of coming out; and reactions to minority sexual identity. Disclosure of sexual identity at work is seen as important to enable the person to 'be themselves' and where this is facilitated the effect on work performance is positive. However, once the disclosure is made then the person becomes vulnerable to the responses of others. The example offered is that of fire fighters using shared showers where a new connotation is introduced through the disclosure.

Valentine et al. (2003) explore the disclosure experiences of young people to members of their families. This disclosure is presented as complex, family specific and fraught with difficulty. It is one 'coming out' context where disclosure can be negotiated through a third party (usually the mother) and managed carefully in relation to anticipated outcomes. However, Valentine et al. (2003) do not make recommendations from their discussion. Instead they argue that the development of the young person as an individual is likely to be more positive where the response to disclosure is positive and measured. This is important because disclosure to the family is often an early step in coming out. Where this is met with support then the young person is more likely to develop self-confidence and a positive self-perception which enables them to disclose in other contexts. It provides them with a foundation for disclosure in future life.

Disclosure is seen as an ambiguous process that can be affirming for the individual while at the same time resulting in serious, and sometimes negative, outcomes. These may include degrees of stress, both for the person disclosing and those to whom the disclosure occurs, sometimes violence and also grief responses (Taylor 1999; Wilton and Kaufmann 2001). The ambiguity of the process can, in turn, lead to ambivalence by the individual to their own sexual orientation. To what extent this ambivalence is a basic feature of coming out is not clear. What is clear, however, is the psychological drive to reveal essential

elements of the self in whatever forum this becomes possible (Jourard 1971a; Markowe 2002; Cant 2005).

The nature of coming out, its positive, negative or neutral effect and the extent to which circumstances influence outcomes are important questions. The answer to these questions will depend largely on the individual and those to whom they are coming out or disclosing. Coming out can be an instance of a discursive process that renegotiates the self in different situations so it can be absent, partial or complete depending on the circumstances (Ward and Winstanley 2005). The real question is whether or not the neutrality of the act of coming out is related to its consequences. If the outcome is negative and the response 'violent' then the process of disclosure could potentially be viewed as negative. However, the outcome may not determine how the process is defined for the person who is making the revelation. It may be a sufficiently positive and affirming experience that the short term consequences are deemed a side issue of an act that is otherwise considered the 'right' thing to do (Kus 1985). The inclination of a gay man or lesbian woman to come out in a range of circumstances depends on a number of factors, including how they feel about themselves and the ways in which close friends and family have responded (Griffith and Hebl 2002).

As discussed, research by Griffith and Hebl (2002) set out to test a set of hypotheses based on previous research into coming out and psychological

assumptions about disclosure behaviours and consequences. Decisions not to disclose have been associated with poor psychological health (Jourard 1971a), increased levels of poor physical health, and the adoption of avoidance and 'covering' behaviours which start to dominate the individual's life (Cole et al. 1996). Although Griffith and Hebl's (2002) hypothesis that the centrality of sexual orientation to the individual did not impact upon decisions to come out, the extent to which the individual felt positive about their sexuality did. In other words, it mattered less that the individual thought their sexuality was an essential part of self requiring expression and performance, than that they felt comfortable with, and positive about, their sexuality. This could be important when considering disclosure of sexual orientation in the formation of identity. Is the created identity positive or negative, for example?

This acceptance, and the need to disclose sexual orientation in a variety of life settings, is an important theme within the literature. As suggested previously, disclosure of sexual orientation is part of the process of identity formation. The individual becomes who they are, partly through the act of disclosing but also through their own responses to this (Taylor 1999). This process is not linear or abrupt but a complex interaction between a range of variables in a range of situations. It can also be a negotiated process whereby the discloser reveals and conceals within a constant reassessment of the reactions of those around them. The 'confession' of non-heterosexuality results in the act of 'coming out' and revealing homosexuality. Taylor (1999) argues that, because of this dynamic, the

individual is not homosexual 'in the world' until the coming out process is undertaken. This is part of the intrinsic, and seemingly unavoidable, invisibility of minority sexual orientation. However, the dominance of heterosexist assumptions across the majority of societies means that this identity (being homosexual) is not fixed because it requires the individual to come out again and again in different times and places in their life (Ward and Winstanley 2005).

The nature of 'being gay'

'Coming out' is frequently viewed by the heterosexual population as specifically an expression of sexuality, or with whom the individual has sex. However, this physical aspect is only part of the story. Some people who have same sex encounters will describe themselves as heterosexual while some who identify themselves as lesbian or gay may have intercourse with the opposite sex or may, indeed, be celibate. For some women, their identification as lesbian has less to do with sex than it does with relationships or relating to others. It is something that is a deep and intrinsic part of them (Markowe 2002). It is a state of being rather than a state of doing.

Even in terms of the physical, homosexuality is not a discrete category but is part of a spectrum of behaviours and attitudes that form the individual. The extent of same sex behaviours in the United States led Kinsey to conclude in the 1940s that homosexuality was a minority sexual orientation only because society made it so (Taylor 1999). That an individual's sexuality runs counter to the norms of the

culture within which they live, leads to confusion and dissonance. According to Taylor (1999), consonance can be achieved only if the individual joins a subculture that reflects this sexuality as the norm. However, there is a challenge for the pregnant woman to normalise minority sexual orientation in the strongly heterosexual and heteronormative culture of maternity care. If heterosexist assumptions underlie the whole structure of maternity care, then being gay makes the lesbian woman 'other', and being 'other' may increase the level of vulnerability felt by the woman. This in turn might inhibit disclosure, and inhibited disclosure has implications for health and the health care that is given (Cole et al. 1996). The key seems to be to create a social order which accommodates the other while leaving it unchanged.

Women whose pregnancies and whose maternity care experience fit with dominant norms are inconspicuous and appear 'normal' or usual. They are free to be themselves because they are who they are expected by society to be. Coming out, or disclosing, can be seen as in some way moving from the dominant norms to a place that is distant and separate from the mainstream (Wood 1999). However, for the childbearing lesbian woman this may not be the case. Perhaps the ideal for the lesbian user of maternity care is to try to inhabit the mainstream in a way that makes her visible but not marginal. Some claim that in order to justify difference, marginalised individuals who are creating themselves through their disclosure, do so by relating themselves in terms that others recognise (Wood 1999). In this example, the pregnant lesbian encounters

problems in trying to establish an alternative normality, and one which is so completely in conflict with heterosexist assumptions of childbearing. Being the 'other' means being exposed to scrutiny and often to judgement as those who are 'other' are often subject to suspicion and distrust (Beauvoir 1997). Additional negative connotations of disclosure also affect decisions to disclose. The specific example of disclosure as confession is discussed in the following section.

Disclosure as confession

Disclosure is frequently imbued with the quality of confession (McDonald 2008). Media use of the word 'disclosure' almost invariably relates to a confession or admission of guilt. Disclosure as confession is an important control mechanism throughout society and is part of what Foucault terms 'governmentality' and control of the subject (Macleod and Durrheim 2002). Governmentality is the term used by Foucault to describe the way that power is exercised at a macro level by government and the various supportive structures within society. This includes structures that perpetuate the relative disempowerment of women through pregnancy and motherhood.

The giving of information about the self puts the individual at the risk of becoming subject to forms of control (Gilbert 2001) and all women who access maternity care are requested to disclose. That this is an added dimension of

vulnerability is indicated by the fact that disclosing, and making visible, precludes the possibility of subsequently making invisible that which has been disclosed. Disclosure means it is then 'out there'. The role of the midwife or health care practitioner in this is to take the part of the listener to whom the individual confesses – a role that also includes acting on the confession and exerting control over the confessor (Gilbert 2001). The form which the control takes may differ within each individual therapeutic relationship but the vulnerability experienced by the woman is similar. The issue of control and power is one to which I will return in the discussion in Chapter Eight.

'Confession' is important for lesbian women who may wish to disclose their sexual orientation to their maternity care professionals because it is relevant to their experience. This might be mistakenly viewed by the professional as a quest for acceptance, or for forgiveness, when indeed it may be neither. It might, instead, be a simple statement of fact. A judgement made on the basis of protecting sexual norms could be seen as rejecting the sexuality of the woman and, as a consequence, might have a negative impact on her sense of self (Fraser 1999). This impact clearly depends on many factors such as the personality of the woman and the extent to which she is comfortable with her own sexuality (Kus 1985). The developing and 'living' of an identity that reflects the perceived true self of the individual is a psychological necessity and much has been written to confirm this (Taylor 1999; Sanitioso and Wlodarski 2004). By 'rejecting' the validity of this self, the midwife or other health professional might well disrupt or

disturb the person's deeply held belief about who they are (Mulligan and Heath 2007). The impact that this will have certainly depends on the individual woman but it cannot be assumed that the woman's sense of identity will not be adversely affected by the attitudes of others, particularly if she herself feels ambivalent. This is discussed further under the heading *Disclosure and identity*.

Confession as narrative identity

There are, however, different and arguably less negative interpretations of disclosure as confession and this is found in the act of telling one's story. In a discussion of 'coming out' expressed through memoir, Jolly (2001) argues that the coming out story of men and women from sexual minorities is a legitimated use of the traditional autobiographical literary style. These types of stories are often attempts to find a recognisable place in society in the same way that someone else might through what Jolly terms 'narratives of revelation and conversion' (Jolly 2001, p.476); in other words, a form of confession in which the storyteller attempts to renegotiate identity and function. This is particularly true when the confession is recognised and validated by others. The response of others helps the individual to find themselves within the wider social context.

Confession and its role in the formation of identity is also discussed elsewhere in the literature, notably in relation to Wittgenstein's and Nietzsche's style of philosophy (Nietzsche 1961; Wittgenstein 1972; Peters 2000). Philosophy as a way of life means that the individual discloses and confesses through thought

processes and through allegory. Trying to provide the answers to deep questions of the world and the universe means revealing something of the individual. It also means creating the individual through confession. However, this position is not without its problems. The self and identity are socially constructed and are interpreted contextually. This means that the self revealed through confession in one social setting will be a different self in a different socio-political setting. Foucault (1999) also refers to confession as part of self in his discussion of religion (Foucault 1999). Confession, in his view, is used in Christian religion as an expression of the true self. It is about self-knowledge and the religious subject has a duty to confess in order to know who he or she is (Carette 1999).

However, confession is a very specific form of disclosure with a specific purpose relating to a degree of guilt. Disclosure in its neutral and more positive senses can also be closely related to identity expression and formation. Disclosure of sexuality can be a validating, chosen and positive act. How it relates to identity is the subject of the next section.

Disclosure and identity

Exploring the nature of disclosure in relation to fundamental elements within women's lives or 'being', it seems that an obvious related area is the concept of the self. The self is an elusive concept that lies in the domains of psychology, philosophy, sociology and theology. There is a significant body of literature

relating to this concept although not all of it considers the role of disclosure. It is only the literature that relates to *disclosure* and identity that will be included here.

Theoretical perspectives

Social psychology explores the concept of the self in great detail, giving a number of explanations for the definition of the self as well as how it is developed and maintained. These theoretical frameworks relate largely to how individuals see themselves, what they believe they are like as people (e.g. rich, successful, happy and intelligent) and whether others see them in this way (Strawson 1997; Elliot 2005a). All these characteristics seems to relate to superficial factors which do not necessarily make up the individual's being – the 'who I am' rather than the 'what I am'. The predominance of theories of personality that reduce the individual to a set of traits is not without its critics (McAdams 1996). McAdams (1996) argues that there is a need for some theoretical development to bridge the gap between human traits and the self and 15 years on this is still not the focus of identity theory.

Theory of the self can also be situated within phenomenology, which explores the way individuals experience reality rather than defining what is empirically or demonstrably real. There are two elements within this theoretical perspective: *"(1) what we perceive is not necessarily the same as what exists in the real world and (2) our behaviour depends more on the world as it appears than as it actually*

exists” (Brown 1998, p.6). Linked to these ideas is the idea of Gestalt theories of perception – that the psychological world is not the same as the real world (physical world). Disclosure of sexual orientation may go some way to bridging the gap between the psychological world of the woman and the physical world of maternity care.

The concept of ‘I’ and ‘me’

In psychological perspectives, what is also important in disclosure of sexual orientation is the interplay of the concepts of the ‘I’ and the ‘me’. In identity theory, the ‘I’ is the part that perceives and the ‘me’ is the part that is perceived (Elliott, 2005a). These parts of the individual and their sense of self are related to the separation of individuals from other people and from the material world. It would seem likely that the ‘being’ in relation to the importance of disclosure in maternity care would reside within the concept of the ‘me’. This area requires further exploration in order to identify the important aspects of the self that can be utilised as a theoretical framework through which to explain the importance of identity and experience in maternity care. However, one important and relevant function of the ‘me’ is that it allows individuals to view themselves with continuity rather than simply seeing themselves anew each day (Strawson, 1997). This means that the self is not negotiated each day but continues and develops over time. This speaks to the concept of the self as developed over a life, and includes the impact of life changes such as having a baby.

Markowe (2002) takes this further in stating that a vital aspect of coming out and of being gay is the coming out to self. Markowe (2002) argues that the lesbian woman must be able to acknowledge her sexuality to herself before she can acknowledge it to others. If this is to be possible, she must first see the lesbian identity as being one which exists. Not only that, but Markowe argues that this identity must be represented as something positive and having value. This is an arguably contradictory position given that coming out does not always lead to positive outcomes, regardless of how the individual views their sexual orientation. It has been suggested that the way that gay men and lesbians are represented in the public consciousness will have an impact on the woman's feelings about identifying herself as part of this particular group (Wood 1999). This is both supported and refuted by Griffith and Hebl (2002) whose study demonstrated that perceived positive feelings towards gay and lesbian people by work colleagues was a factor in decisions to disclose but that the disclosure itself did not necessarily lead to improved psychosocial outcomes.

The self as 'I am'

A related concept is that of 'I am' and this is an inherent part of any disclosure because it is about revealing the self and enacting the individual. But what does 'I am' mean? The underlying hypothesis of disclosure and the self here is that the self exists at a fundamental level that does not involve situational interpretation and does not depend on time and external influence. This can be described as "the 'me' that is in my head". Psychological and sociological theories of the self

do not provide a sound theoretical basis for this contention, as they are too influenced by contributing factors such as upbringing, nature/nurture debates, interaction, and labelling, significant relationships and how we want to be (the self we want others to believe we are) (Goffman 1963; Markowe 2002).

The possibilities for a theory to underpin the study of disclosure in relation to the self as an 'I am' may well come from philosophy. Indeed this perspective already exists in philosophical discourse on the self and, although sounding esoteric in nature, exists independently of theology and the concept of 'the soul' (Strawson 1997). The following statement neatly sums up what is meant by 'the 'me' in my head':

"What, then, is the ordinary, human sense of the self, in so far as we can generalize about it? I propose that it is (at least) the sense that people have of themselves as being, specifically, a mental presence; a mental someone; a single mental thing that is a conscious subject of experience, that has a certain character or personality, and that it is some sense distinct from all its particular experiences, thoughts and so on, and indeed from all other things" (Strawson 1997, p.407).

Strawson (1997) provides a phenomenological framework within which to explain the sense of the mental self which he believes is a reality that can be defended through the use of this framework. What is important here is the

contention that the self exists as 'a thing' and that this thing has properties that can be identified and therefore must have a significant place in the individual.

The self as an entity

Singularity is important in philosophical discourses relating to the self as a 'thing' because, it is contended, if it is a thing then it must be a single entity. The example that Strawson (1997) gives is that of a marble in a pile of marbles. The single marble is better at maintaining its status as a thing than is the pile. He also argues that the self, as with all other 'things' is single in the sense that it is determined as such by the terms of reference used to describe it (the 'principle of objectual unity' p.412). In the same way that a car is a singular object made up of as many parts as we care to mention depending on how far we want to deconstruct its integrity, so the self is singular.

This issue of identity, singularity and perpetuity forms the basis of the much-debated philosophical problem of *The Ship of Theseus* (Westphal, 1997). The greatest philosophical minds, including Plutarch and Hobbes, have discussed the integrity of identity over time, using the example of the ship which has the planks replaced periodically. At what point the ship becomes a different ship is open to much theorising but the concept of identity as something that changes and yet remains the same, is an important one.

The question of the self as a singular entity that is not simply part of the collective is also discussed elsewhere, for example within the concept of Bildung which is a theory of personal development or self-actualisation. Derrida is cited as identifying the singularity of the self and uniqueness of the individual as being fundamental to Bildung as a philosophy of personal development (Wimmer 2001). The self as a singular entity must exist and be understood if this level of personal development is to take place. This means that in philosophical debate the self is seen as something real rather than simply socially constructed or interpreted.

Self-knowledge

Another important issue in identity is that of self knowledge, and within this is the theory of the storied self or narrative lives (McAdam, 1996). This is useful in dialogical research (such as hermeneutic phenomenology) as the self is constructed through the telling of the individual's story (the relating of the experience). This is also important in maternity care. After all, health professionals are asking women to tell their stories in order to build up a picture of the woman and who she is. If the woman feels unable to tell this story then does it affect her identity? Does she miss some vital element in the development of self because she has been through a life changing event without being able to disclose or be herself?

The narrative of each individual is the story of the unique and is told in order to situate the person in the culture (Steffen 1997) - to locate them. The idea of stories as a way of telling ourselves goes back well into historical and even mythical times. The Norse sagas that were handed down through generations are just one example of how a social identity is maintained through the passage of time. There appears to be a drive to tell ourselves to others and to relate who we are (Wood 1999). The person is created and articulated through the life story.

In maternity care, revealing parts of the embodied and essential self becomes part of the process of having a baby. The body is exposed but so is the inner person. Becoming a mother, whatever that may mean in practical terms, is a life event that changes a person from who they were to something different (McAdams 1996). It is a deep psychological process entailing important psychological conditions that make the change a positive or a negative one – a ‘successful’ change or one that is problematic. Part of developing the self and internalising change is to be able to acknowledge the person who is there to start with. *Knowing* yourself is related to *being* yourself, and being yourself is an intrinsic part of disclosure (Cavarero 2000). Indeed, self is an intrinsic part of the individual even if it is enacted in different ways depending on circumstantial and situational factors. It is an expression of the ‘I’ or the ‘I am’.

So the idea of the self as something that is ‘essential’ within the individual is one for which there is a theoretical basis. The *‘me’ that’s in my head* exists within

philosophical debate and discourse. If the self is something that is real and is as much a part of the person as a limb, then it should be afforded the same respect as the limb. This theoretical and philosophical position can be applied to maternity care. As discussed in the background to this thesis in Chapter One, midwifery in particular aims to provide woman-centred and individualised care that is capable of taking into account all of the parts of the woman. If the self is not acknowledged, or the impact on the self of the experience of maternity care in certain conditions is disregarded, the woman has not received individualised woman-centred care. The aspiration itself is rendered futile in the absence of adequate understanding of the role and centrality of the self, and how it relates to disclosure of signifiers such as sexual orientation.

Disclosure and health

There is a significant body of literature within the discipline of psychology relating to the ways that disclosure can contribute to improved levels of physical and psychological health (Jourard 1971a; Pennebaker and Beall 1986; Frattaroli 2006). There is evidence that a link exists between disclosure and aspects of wellbeing: physiological; psychological; emotional; social. It is important here to differentiate this disclosure from the type of disclosure used in psychotherapy which is about the *content* of the disclosure. The aspect discussed here is the *process* of disclosure. These two perspectives are generally distinct in the

literature, and psychotherapeutic perspectives are therefore not included in this thesis.

Jourard

Much of the current work on this perspective of therapeutic disclosure is based on Jourard's work in the 1970s, and his development of the Jourard Self-Disclosure Questionnaire. Jourard's original work (1971a) posited the idea that disclosure itself maintained health (physical and psychological), through improved relationships with others and lower levels of social isolation. He also argued that disclosure would lead to disclosure. The reciprocity of disclosure would lead to improved social relationships and improved health. Jourard also found that the most effective dyad of disclosure was woman-woman, which is the prevalent dyad in midwifery practice. This makes it a relevant theoretical perspective for midwifery practice. In addition to his academic publications, Jourard also published a particularly interesting populist book *The Transparent Self* (Jourard 1971b) which aimed to address the problems within the United States in relation to ethnic and social diversity. The primary message in this book is that true satisfaction in life comes with creativity beyond social constraints and a reinventing of self where individuals are honest about how they feel in relation to having to fit with social ideals. Jourard (1971b) offers the example of the middle class model of family which he recognised as not working and not reality in many cases. As the following passage demonstrates, this has particular resonance for this doctoral thesis:

“Many families simply are not fit for their members to live in. This hypothesis asserts that conformity to familial roles produces dispiriting, stressing untenable situations which culminate in physical illness for some and neurotic or psychotic breakdown in others. The role definitions and modes of relating designated ‘normal’ serve more to produce a cosmetic image of family life and to maintain the status quo than to foster personal growth and full functioning. Current professional service to families, whether from physicians, social workers, pastoral counsellors, or family therapists serves more the function of perpetuating existing family structures with all their pathogenic power, than that of reinventing family structures that maximise zestful life of the participants” (p.103-104).

Jourard’s argument is that failures to disclose and to ‘be ourselves’ come as a result of pressure to conform to social expectations, and that professional roles work to perpetuate those norms through failure to recognise variation. This is still the case in current practice as will be discussed in Chapter Three of this thesis.

Despite its appeal, Jourard’s work is not without its problems. His work was often limited by the small numbers of participants in his studies. In experimental research it is generally expected that to demonstrate an effect the number of participants should be sufficient. In Jourard’s work it is not always easy to tell if

the studies were sufficiently powered as there is little focus on that level of detail in the reported studies. In addition to the issue of small sample size, Raphael and Dohernwood (1987) offer a further critique of Jourard's work suggesting that the Jourard Self-Disclosure Questionnaire (JSDQ) contains confounder items which are symptom-related. Symptom-related items are those which are more likely to be reported by individuals with particular conditions, for example asking the respondent if there are aspects about themselves that they do not like is more likely to elicit response from a person with depression. These symptom-related items limit the ability to associate disclosure with health outcomes, although when excluded the results demonstrate that disclosure of symptom-independent items was associated with higher levels of mental health. Well individuals are more likely to be the ones who have higher levels of self-disclosure, although it could also be the case that well individuals are more inclined to self disclose than those with a mental illness. The direction of causality is unclear.

Pennebaker

Despite the limitations in some of Jourard's empirical work, self-disclosure continues to be used as a therapeutic technique in psychology. The premise of self-disclosure has been significantly developed and expanded upon by Pennebaker, and others (Pennebaker and Beall 1986; Pennebaker et al. 1990; Pennebaker and Francis 1996), in the development of a therapeutic approach using emotional disclosure of traumatic events. Theoretically, in emotional disclosure the process of writing about previously undisclosed traumas leads to

improvements in health overall and this includes physical health with visits to health centres or general practitioners being an outcome measure. This is interesting from the perspective of these studies as the definition of traumatic is individual-dependent. It is flexible enough to include sexual orientation, although this might not normally be described as traumatic. For example, in a study by Greenberg and Stone (1992) 26% of the 60 participants chose issues relating to sexuality as the traumatic issue about which they disclosed in their writing. Greenberg and Stone (1992) also found that those who wrote about incidents they described as 'highly traumatic' demonstrated improved health outcomes, supporting a link between disclosure and wellbeing. It is true that all of the participants were healthy undergraduate students and all of them subjectively defined the level of trauma about which they were writing. However, the link between disclosure of severe trauma and a reduction in physical complaints was nevertheless made. It is also the case that included within these definitions of severe trauma was sexual orientation suggesting that where an individual considers their sexual orientation to be a traumatic issue then being unable to disclose it might impact upon their health.

Pennebaker has generated a significant body of work in relation to the use of emotional disclosure as a therapeutic intervention, including popularised literature for using writing as a way of healing (Pennebaker 2004). His work is based on a premise of inhibition theory where the lack of disclosure acts against the individual as a kind of 'low grade' but long term stressor. This then leads to

poorer health. The corollary of this is that disclosure of the trauma releases the inhibition and removes the stressor. It is an unfacilitated process where the individual discloses only to themselves. In a review of 11 articles reporting studies using this approach, Smyth (1998) was able to demonstrate improved outcome levels in experimental groups with higher numbers of male participants. This effect can be linked back to Jourard's (1971a) work where disclosure was more common between women. Smyth (1998) recognised that men tend to disclose less to others and so the benefit of disclosure in the form of writing is heightened in their case. This meant that studies with higher numbers of male participants demonstrated greater levels of effect. A further interesting point to note here is that Smyth (1998) controlled for Pennebaker as a named author. Using additional statistical analyses of studies not listing Pennebaker as an author, he was able to eliminate theorist bias as an influencing factor.

Testing the theory

Two large meta-analyses have been undertaken in relation to the literature on emotional disclosure (also known as *experimental* disclosure): Meads and Nouwen (2005) and Frattoroli (2006). They explored a large number of published studies using the intervention of disclosure and it is important to remember that the content of the disclosure is not important. It is the process of disclosure that is key to its therapeutic value. Because of this, the focus on studies varied.

The findings of these meta-analyses are contradictory and not unequivocal. Meads and Nouwen (2005) found that, despite an assumption that emotional disclosure would be an effective therapy, the meta-analysis of the 61 studies did not support its use. Meads and Nouwen (2005) speculate that reporting and publishing bias within these research studies potentially reduced their veracity because at times outcomes were measured in the studies but not then reported. Although this is speculation, it is easy to draw the conclusion that if particular outcomes were measured but not reported then they did not support the hypothesis.

A second, and somewhat larger, meta-analysis was undertaken by Frattaroli (2006) at around the same time. This included an extensive review of the literature and the theoretical perspective surrounding disclosure. This meta-analysis also sought to explore the variables across the 146 included studies, for example participant variables, treatment variables and methodological variables. The overall conclusion of the analysis was that experimental disclosure is an effective therapeutic technique. This is qualified by an extensive breakdown of categories to establish the detail of the effects. Some broad categories of outcomes showed significant effects, but when broken down into more precise parts only some demonstrated significant effects. Not all outcome measures were addressed in all of the studies, and in such a broad meta-analysis it is clear that categories will be described differently (described or identified using different terminology) with not all studies assessing the same outcomes in the

same way. Psychological health was measured in 112 of the studies, whereas physiological health was measured in only 30. One of the categories of psychological health demonstrating a significant level of response was that of *positive functioning*. This included a range of subcategories such as *mood*, *happiness*, and *satisfaction with life* (Frattaroli 2006, p. 841). In the transition to motherhood it would seem appropriate that levels of *positive functioning* should be promoted through the care that is given. If disclosure is part of promoting life satisfaction then inhibiting disclosure should have the opposite effect. In the physiological outcomes improved liver function and HIV viral loads were the only statistically significant findings, although this is most likely due to disclosure as part of accessing and engaging in treatment (Frattaroli, 2006).

Other subjective outcomes were also assessed including *reported health*, *health behaviours*, *subjective impact of the intervention* and *general life functioning*. These are important categories from the perspective of this doctoral study because pregnancy generally involves a well population, so quality of experience and satisfaction are key outcome measures. Positive attitude towards the intervention (disclosure) and attempts to make sense of the event (in this current study this would have to be the issue of sexual orientation) were significantly increased.

Of course, with the therapeutic technique of experimental, or emotional, disclosure a key difference from disclosure in health care is that the individual

does not disclose to another. They are simply writing about an incident or issue to which they assign personal significance or deem to be traumatic. However, although the context of my study is the verbal disclosure to another party, Frattaroli (2006) does find evidence that disclosure leads to increasing levels of disclosure to others and increased levels of social engagement. It is not possible to make a direct comparison between written disclosure and disclosure as part of an episode of clinical history-taking but it is possible to say that disclosure has positive physical and psychosocial effects.

Non-therapeutic motivations for disclosure

Not all research into disclosure explores its formal therapeutic purpose. Individuals often make their own decisions to disclose significant, or traumatic, factors to others, and these disclosures may lead to benefits for those individuals, although equally they might lead to adverse outcomes. In a small scale qualitative study exploring women's decisions around disclosure of HIV status (Kimberly et al. 1995) the participants identified a number of personally important motivations for disclosing. One of these was the need to 'get it off their chest'. The keeping of the secret was seen as a cause of extreme stress and the point came where the women felt they had to tell someone, regardless of the outcome. In addition to these personal reasons for disclosing there are instrumental purposes to disclosure: disclosure is necessary for treatment and therefore, without disclosure, health outcomes are unlikely to improve. A model of disclosure is presented within the paper as well as points of intervention that

could be used by clinicians. However, this presumes that there will be a clinician available for therapeutic intervention at the relevant points of disclosure. Given that the study explores the women's decisions around disclosure to friends and families it seems that the disclosure context is not comparable and so the model does not appear to derive from the findings.

Inhibition and stigma

Although it is fair to say that there is some disagreement about the extent to which disclosure has benefits to a person's health (Jourard 1971a; Cole et al. 1996; Taylor 1999) it is certain that for reasons of assessment, rapport and the therapeutic relationship disclosure has a purpose in health care. It is dependent on a number of factors, not least of which is the anticipated outcome. As Jourard (1971a. p.17) puts it:

“self-disclosure produces consequences, influencing the behaviour of others towards oneself for better or for worse. Possibly, then, persons disclose or fail to disclose themselves in accordance with the consequences that they may expect to follow.”

It has been argued that the expectation of a negative outcome is more likely to lead to closeted behaviour (Kimberly et al. 1995) and the issue of stigma was

introduced earlier in this chapter. There is some evidence to show that where disclosure is inhibited, health outcomes are significantly poorer as existing disease progresses more quickly (Cole et al. 1996). The reasons for this may not be the failure to disclose itself, but that those who do not feel able to disclose may also feel less able or be less inclined to seek appropriate medical help or participate in their medical care to the same degree as those who disclose. So disclosure of sexual orientation and the many factors that relate to it is deemed to be important in the success or uptake of treatment (Kimberly et al. 1995).

Although undertaken fifteen years ago, Kimberly's et al. research (1995) also links well to the study population of this doctoral research. They argue that the focus on the gay male population in HIV research means that women with HIV are often invisible and under-represented. It is the association of a particular health status with a particular population that renders specific groups invisible in particular health contexts. The pregnant lesbian is another of these invisible groups in the context of human reproduction and maternity care.

Decisions around disclosure are very closely related to stigma and the degree of perceived stigma associated with particular types of disclosure. Sexual orientation is a very good example of this but a similar example is mental illness because of the way it is perceived by society. Stigma is the value laden interpretation of the meaning of, for example, mental illness or sexual orientation (Goffman 1963). It introduces a lack of congruence between the way

an individual is viewed and the way they view themselves. It is this lack of congruence and its associated discomfort that inhibits disclosure when public censure is possible. However, it is not always possible *not* to disclose because disclosure can be informal, related to unconscious expression of the facet being hidden (Williams and Healy 2001). So behaviour is congruent but unintentional as in the behaviours exhibited in depression. The behaviour associated with the manifesting mental illness can be damaging to individuals and to those around them but the fear of stigma prevents that person from formally disclosing and seeking help. This is not to suggest that homosexuality requires 'dealing with' or indeed treating but that fear of disclosure can have health outcomes related to not meeting individual needs. This goes some way to explaining its importance for lesbian women accessing maternity care and situating sexual orientation in the debate on individualised-care in midwifery.

A summary conceptual analysis

In this final section, the different elements of disclosure are analysed under the headings of a concept analysis. Although criticised by Paley (1996) and Beckwith et al. (2008) for being reductionist in nature, concept analysis offers a way of organising information about a concept under scrutiny. To this extent it has some value, and is being used here as a way of bringing the elements of this Chapter together. A concept analysis is a way of enabling theorists to identify the features that separate it from other concepts, so that it can be described (Walker

and Avant, 2005). It is an incomplete process, where the theorist must recognise the fluidity of the concept over time. There is never a finished, or definitive, 'concept'. However, it is being used in this Chapter to bring together the elements of the concept of disclosure, as discussed within the literature review.

Walker and Avant (2005) offer a framework within which to organise the elements of the concepts. The three main aspects are: the concept's attributes; antecedents; and consequences.

Attributes

The literature review has shown that disclosure has a number of attributes, although taking Paley's (1996) point, it is not possible, nor is it necessarily desirable, to map a whole concept. The contextual aspect of any concept will make this impossible. Walker and Avant (2005, p. 68) describe a concept's attributes as the "defining characteristics...very much like the criteria for making differential diagnoses in medicine."

Within this literature review, it is clear that disclosure is complex and multifaceted. Categorising these within a concept analytical framework, the principal attributes of disclosure can be seen to be: a process seen as essential for health and wellbeing (Jourard 1971a; Cole et al., 1996; Griffith and Hebl, 2002; Pennebaker 2004); a process that can be verbal or non-verbal, singular or ongoing (Brown, 1998; Taylor, 1999); the revealing of something hidden (Butler

1990; Kimberly et al. 1995; Smyth 1998; Ward and Winstanley 2005); an exchange of information used in identity formation (McAdams 1996; Strawson 1997; Elliott 2005a; Dibley, 2009); internal or external to the individual (they can disclose or be 'disclosed') and that has value (Kus 1985; Markowe 2002).

Disclosure is a process with purpose, although it is not always undertaken with a purpose in mind. To this extent it is a process with consequences regardless of motivations. However, the consequences of disclosure will be discussed last in this section, following a discussion of its antecedents.

Antecedents

Within a concept analysis, antecedents are those criteria that are necessary for a concept to exist (Walker and Avant, 2005). In this review of the literature on disclosure the antecedents vary in relation to the context in which the disclosure takes place. There are several antecedents but the primary one is the presence of an aspect of the individual (either personal or within his or her life) that is not obvious to others. Disclosure would not be necessary where nothing is concealed. In terms of diversity, this is what Ward and Winstanley (2005) describe as diversity that can remain invisible. Diversity is not the only aspect of the individual that could be concealed. Health status is also relevant here, for example HIV (Kimberly et al. 1995) or mental illness (Prior et al. 2003), neither of which are obvious from the outside perspective.

Secondly, the risk of disclosing must be outweighed by the need to disclose. The impact of stigma on disclosure has been discussed within this chapter, and has been shown to influence decisions to disclose (Cunningham et al. 2009; Prior et al. 2003). Disclosure of sexual orientation at work is also influenced by potential responses of others although the disclosure is seen as necessary by individuals in terms of consonance with their identity (Griffith and Hebl 2002).

A further antecedent is the perception that the disclosure is necessary, for example for the purpose of accessing healthcare (Kimberly et al. 1995) or for establishing an appropriate subject position (Ward and Winstanley 2005; Butler 1990), and for being 'yourself' (Caverero 2000). There might also be a perception in the individual that disclosure is unavoidable, because of its essential nature. These antecedents are multifaceted and vary with individual circumstances, covering the variety that is the human condition, but the sense that it is a complex, instrumental and motivated action underlies disclosure.

Consequences

As would be expected with a concept as broad as disclosure, there are several consequences. Some of these are positive and some are negative. As with the antecedents, the consequences are highly contextual, and this probably relates to the fact that disclosure is a process rather than a concept per se. These consequences within the literature can be classified under the following headings: moral outrage and disgust (Kimberly et al. 1995); vulnerability (through

being put in a position of increased risk) (Griffith and Hebl 2002; Smythe 2010); increased psychological and physical health (Jourard 1971a; Pennebaker and Beall 1986; Pennebaker 1990; Greenberg and Stone 1992; Cole et al. 1996); and being known, which links to visibility and identity (Kus 1985; McAdams 1996; Strawson 1997; Caverero 2002; Markowe 2002).

Outcomes in relation to health are strongly represented within the general literature on disclosure, reviewed within this chapter. This is an issue that will be explored further in Chapter Three, specifically in relation to disclosure and maternity care.

Conclusion

The discussion of disclosure of sexual orientation in maternity care includes a range of concepts related to disclosure and to coming out as lesbian. The importance of including verbal and non-verbal disclosure has been highlighted. The role of disclosure in identity formation has been explored although the breadth and volume of literature on this subject is vast so the discussion is limited to disclosure and identity. Key elements believed to be important for lesbian women disclosing sexual orientation (or not) in maternity care have been identified.

The ways in which individuals disclose essential elements of themselves has also been discussed. This is important for maternity care because it is a significant life-changing process that creates a mother and creates a family. The health of both may depend to some degree on the perception of a positive experience and the accessing or receiving of appropriate care. Verbal and non-verbal disclosure both have roles to play in the overall experience of childbearing.

What is of fundamental significance in relation to the broad definitions of disclosure in the participant groups in this doctoral study is that what makes them marginalised cannot be seen. It remains invisible unless consciously revealed. Other marginalised groups are often unable to hide what makes them different, for example race or disability. A lesbian woman must generally identify herself as such if this is to become known by others. The decision making process around whether or not to disclose is something that needs to be explored further and has been considered within this study.

In Chapter Three the discussion will focus on maternity care as the locus of disclosure and assessment as its function in clinical history-taking. These are clearly important in understanding the relevance of disclosure for pregnant women and for midwifery and help to move the discussion from the general to the specific.

Chapter Three: Disclosure in health care contexts

Introduction

In Chapter Two I provided a foundation for this thesis in exploring a number of definitions of disclosure in order to present it as both complex and important in human existence. In order to align disclosure more closely with lesbian women's experiences of disclosure in pregnancy, this chapter will bring the discussion into the realm of maternity care. Jourard's attempts to establish disclosure as a prerequisite for health may only have been partially successful but it is undeniable that disclosure forms a fundamental part of healthcare. It is central to the assessment process and is a cornerstone of healthcare provision in almost all its forms.

Disclosure of sexual orientation in health care settings

There is a significant body of work exploring the experiences of LGB² people in health care settings within countries such as the UK, USA and parts of Europe. These experiences relate both to users of services and also to health care professionals. This body of literature is almost entirely qualitative in methodology, often with small sample sizes, but the findings are largely consistent. In many cases the outcomes of the studies indicate ambivalence in

² In the context of the discussions in relation to maternity care LGB is being used in preference to LGBT as this doctoral thesis does not focus on the complex situation of retained fertility after gender reassignment. Health care experiences of transgender individuals are important but not relevant to this study.

terms of the quality of experience. Although positive outcomes are almost always present in the literature, fear, uncertainty and poor care are also reported (Salmon and Hall 1999; Williams-Barnard et al. 2001; Wilton and Kaufmann 2001; Steele et al. 2006).

Fear of 'cruel care' was expressed within interviews in Williams-Barnard et al. (2001) and led to failure to disclose to health professionals or in some cases to access care at all. This study was a very small pilot study with only four participants and lacking theoretical saturation. However, in its role as a pilot it raised relevant questions about the experiences of lesbian women in organisational contexts. If 'cruel care' is one of those experiences then this contradicts the philosophy of woman-centred or client-centred care. While there have been improvements in the ways that healthcare needs of the LGB community are approached there is certainly evidence that gay people who disclose their sexual orientation have poorer experiences (Brogan 1997; Williams-Barnard et al. 2001; Wilton and Kaufmann 2001).

Wilton and Kaufmann (2001) remains one of the largest studies exploring lesbian mothers' experiences of maternity care in the UK. The study population comprised 50 lesbian women although some were relating experiences from more than one pregnancy: 65 in total. While the women generally experienced care with which they were happy, there were aspects of care that were of much poorer quality. Those episodes of care where the midwife was required to

interact in a more informative way appeared to be most likely to cause problems: specifically the booking appointment and antenatal education. Midwives were less likely to be able to provide appropriate information and advice to lesbian couples, for example in relation to contraception, but were also guilty of stating their personal opinions about same sex relationships. These factors affected the overall quality of the maternity care experiences.

It is generally accepted that disclosure is necessary for the individual to receive the best and most appropriate care although it might be the case that without disclosure the individual receives adequate care (Williams-Barnard et al. 2001). This is not simply true for the health of LGB people but for health across all populations. Where the link between health and sexual orientation becomes clearer is in relation to health conditions to which stigma is attached, as discussed in Chapter Two; specifically the disclosure of mental illness. Corrigan and Matthews (2003) apply models of disclosure developed in relation to the concept of coming out within the LGB population to discuss the impact of disclosure of mental illness as a stigmatized state of being. Using the examples drawn from disclosure of sexual orientation they conclude that openness leads to familiarity which leads to acceptance and therefore the same could be applied to mental illness. It is the stigmatized nature of mental illness that causes the individual to closet the fact of their mental health condition (or, from the original research, their sexual orientation) because the consequences of coming out are so unknown and so variable. For the individual, expectations for outcomes are

based largely on knowledge of social attitudes to the stigmatised issue. The positive benefits of coming out are recognized at both a personal and a community level and so the argument is made that those with mental illness would benefit at a micro and macro level from disclosure as has been seen in relation to sexual orientation (Corrigan and Matthews, 2003).

Disclosure of sexual orientation in healthcare settings is seen as a constant negotiation in unknown waters. It is viewed by lesbians and gay men as a risky activity because the response by the person to whom they disclose can never be fully anticipated and presumably because fears are expressed across the wider LGB community (through the 'grapevine') and therefore reinforced (Williams-Barnard et al. 2001). In some cases the disclosure occurs in one situation but is later withheld because of the negative consequences that occur (Weisz 2009). In a changing legal and political context it is arguable that the outcome is likely to be less negative than in the past, but there are various ways of responding negatively that are not overtly homophobic (Dibley 2009). The lesbian mothers participating in my doctoral research often speculated that the behaviour of others might be related to their disclosure of sexual orientation although, as I discuss in Chapter Seven, such speculations are often moderated to become speculation about the person's general behaviour.

Coming out in health care contexts risks over-sexualizing encounters between health professionals and users of services. This includes situations where LGB

health professionals disclose in therapeutic contexts. Riordan (2004) identifies common practices such as chaperoning male staff who are performing intimate (although not always) examinations with female patients as reinforcing the sexual nature of contact between men and women. Indeed he also argues that this reinforces the heterosexism of society in general because chaperoning occurs only when the health professional is of the opposite sex to the client (and only where the professional is male). Riordan (2004) suggests that the practice of chaperoning is extended beyond intimate examinations to any encounter between a male health professional and a female client. Because the encounter is sexualised through the protective mechanism of the chaperone, if one party were to disclose their sexual orientation as not being heterosexual then this would render as sexual those encounters between professionals and patients of the same sex, in the same way as the encounter between male professional and female client. Riordan (2004) recommends strategies that desexualise therapeutic encounters and encourage trust rather than profess protection. He does, however, acknowledge that this is not necessarily straightforward and suggests that change be made at an organisational level. This is because health professionals perceive themselves to be at risk from complaint and might therefore be unwilling to change practice at an individual level.

Although health care encounters for LGB individuals present challenges, the lesbian mother is often considered an oxymoron in health care (Wilton and

Kaufmann 2001; Lee 2004; Lee 2007) and the specific issues raised by this are discussed in the following section.

Disclosure in maternity care

Pregnancy is a uniquely visible physiological process – unique because it is physical change in the absence of pathology. Less uniquely, it is an episode of the human life cycle that invites close scrutiny and an imposition of the public on the private spheres of human social existence. When pregnant women access maternity services they are asked at various specified points to reveal aspects of their lives that could be considered very personal and generally deemed private. There are few other times in public human life that involve sharing details about sexual relationships, menstruation, sexually transmitted infections, previous terminations of pregnancy and other related aspects of private existence, in the context of one physiological process. In fact, by its very nature, pregnancy reveals itself through the growing fetus and the physical changes in the woman's body. This has the potential to result in a set of socially normative assumptions being applied by strangers – that the woman has had sexual intercourse, that the intercourse was heterosexual and that somewhere there is a 'father' although he may or may not be present.

In the context of discussing the role of disclosure in pregnancy it is evident that maternity care exposes generally private elements of life, bodies and

relationships, and asks women to reveal to strangers some things that they may not even have revealed to close members of their family. The obtaining of clinical histories is important in all aspects of health care given that it forms the basis of assessment. This is a taken for granted element of maternity care but, like all forms of questioning, may result in disclosures, the consequences of which then have to be dealt with. It is good practice (and common sense) in all forms of interviewing to be prepared for the answers to the questions asked. Anticipating possible outcomes to questioning may reduce the surprise element, but when assumptions underpin an interview schedule, for example the heterosexist assumptions in maternity care, then an unanticipated answer can meet with inappropriate or judgemental responses that do not recognise the individuality of the woman (Wilton and Kaufmann 2001).

There are several reasons for the primacy of history-taking, most of which stem from the rhetoric of high quality care. In order for a midwife to provide the ideal of woman-centred, individualised, holistic and appropriate care, it is necessary for the woman to provide the details and the context with which the midwife will to some extent construct the woman as an individual. At some level, this process of construction is based on a set of stereotypes, biases, prejudices and assumptions that are held by the midwife and which may relate to many forms of difference, for example religious belief, ethnicity, race and socio-economic factors. 'Constructing the woman' is a process of relating any identified differences to the dominant norms and adjusting care accordingly. A simple

example of this is the attention to 'dignity' paid to a woman who identifies herself as Muslim because Muslim women are seen as being more protective of their bodies. It could be argued that the midwife applies a separate meaning or subjective quality to the act of maintaining dignity when this is in fact part of her normal professional behaviour. The behaviour and quality of the care might not have changed but the way that the midwife views her actions (for example, keeping the woman covered) might be different in these different cultural contexts.

The disclosure by a woman that she is lesbian and does not belong to the majority heterosexual client population must take place in a context of social discourse that recreates the norm (McDonald et al. 2003). The dominance of heterosexist foundations of maternity care and society in general means that the midwife might interpret difference in its relation to the mainstream. By this I mean that the woman is described as *not* being heterosexual, *not* having a male partner or *not* knowing the genetic make-up of her child. Overcoming this comparison can result in a degree of dialogue between the woman and the midwife that may facilitate a relationship that promotes trust and familiarity. This requires a midwife or other health professional actually to be aware of the potential for lesbian parents to exist and to be more aware of the language that they use. Information exchange is easier and potentially more effective in these circumstances (RCM 2001; Røndahl et al. 2006; Røndahl et al. 2009). This improved information exchange assumes that the midwife and the woman can

find a shared language and an agreed meaning in order to communicate their reality and establish rapport but this is by no means a given. Heteronormative language may prove to be a barrier across which neither party can communicate effectively. However, reciprocal disclosure and the lowering of the professional façade can facilitate disclosure, as someone who is disclosed to is more likely to disclose (Jourard 1971a). This reciprocal disclosure can occur on many levels. A midwife might reveal something very intimate or something very ordinary, but the willingness to disclose engenders trust and promotes disclosure in others. It facilitates an atmosphere of trust. It might be that the disclosure by the midwife is simply an acknowledgement that the woman is lesbian and an admission that the midwife does not know exactly what the implications of that will be.

Language and information

The heterosexist or heteronormative language of maternity care is one that both parties (the midwife and the woman) will probably understand but which one party, the lesbian mother, may not internalise as her own. She may not feel that it relates to her or represents her reality. It comes from a dominant perspective that the pregnant lesbian woman may inhabit only partially. So the problem of communication is not literally the speaking of a different language but the enactment of a culture that is dominant but not unique (Röndahl et al. 2009). The preparedness of the health professional to attempt to cross the barrier and to connect on a meaningful level will enhance this reciprocity of disclosure. The

midwife is, after all, in a position of relative power and should be willing to relinquish some of that power in order to establish rapport and therefore effective information exchange (Wilton and Kaufmann 2001).

The midwife derives power from the requirement to obtain information and make decisions or suggest options on the basis of the information disclosed. The midwife is also ostensibly the holder of knowledge. The woman is expected to provide information which she must trust is relevant and accept the midwife's answers to her own questions and believe that the information is true. It is hard to contemplate a situation in which the midwife would be so keen to provide the same personal information to the woman if the woman requested it, for example previous terminations of pregnancy and detailed obstetric history. It may seem obvious that this information would be irrelevant and that the woman would have no reason to know it. But any pregnant woman disclosing personal information must believe that the midwife does need to know this in order to provide the best and most appropriate care. It is easy to argue that healthcare professionals need to know, but the woman may want to know in order to establish rapport (Jourard 1971a).

This information exchange is not simply a theoretical exercise. History-taking relates not just to knowing about the person for whom care is provided but forms part of the duty of care that the midwife or GP or obstetrician has to each individual woman. Clinical decision-making is based on taking a range of factors

into account and applying clinical expertise. The quality or appropriateness of this decision-making may be compromised if the information on which it is based is incomplete.

‘Patient safety’ and standardised documentation

In the past few years in health care the concept of ‘patient safety’ has been the focus of significant investment in time and money. Interventions such as the use of barcode technologies for coding information (Department of Health 2007) and patient safety initiatives aimed at improving specific patient safety outcomes at national levels (NHS Scotland) have been introduced within the countries of the UK. These draw on the global patient safety network of the Institute of Health Improvement. NHS Scotland’s *Scottish Patient Safety Programme* addresses five specific programmes from reducing healthcare acquired infections to improving change through leadership. The use of standardised documentation forms part of this patient safety approach through early warning systems such as SEWS (Scottish Early Warning System) charts and SBAR (Situation-Background-Assessment-Recommendation) both of which are designed to ensure a standardised approach to communication and decision-making. This is designed to reduce human error by reducing ambiguity but is as yet unevaluated. An analysis of patient safety initiatives is not relevant for this thesis but the concept of patient safety provides a context for the development of standardised documentation in maternity care and this is discussed next.

Standardising information in maternity care

The Nursing and Midwifery Council state that midwives must be able to 'determine and provide programmes of care and support for women which are appropriate to the needs, contexts, culture and choices of women, babies and their families' (2009). This statement comes from the most recent Standards for Pre-registration Midwifery Education (NMC 2009, p.22) and includes specific reference to the taking of the clinical history, albeit the initial consultation (booking visit) only. These are contained within Standard 17 and within the Essential Skills Clusters (ESC). The ESC frames its purposes as setting out the skills that a woman can 'expect/trust' a newly qualified midwife to exhibit.

The NMC have included the issue of information gathering explicitly within the Essential Skills Clusters (ESC) under the heading *initial consultation* (NMC 2009). The rationale for this is that the assessment of need can only be made on the basis that adequate information is obtained at the very start of the pregnancy. Although the exchange of information and the assessment of need are ongoing throughout the pregnancy, the initial consultation, or booking visit, is the baseline against which the woman's pregnancy will be categorised in terms of risk and all future information will be measured. Regardless of the professional debate in relation to the value of ESC, it is self-evidently true that it is not possible to make an assessment of risk or an evaluation of need without some basic information provided by the woman. In addition to this, the midwife must make an accurate assessment of the information. For midwives in Scotland, this

consultation and information exchange takes place through the medium of the Scottish Woman-Held Maternity Record (SWHMR). All of the episodes of care within this doctoral study predate this document which came into use in 2008. However, it is relevant in the context of the discussion of the issues raised within the dialogues.

The SWHMR is a standardised record of maternity care developed by NHS Quality Improvement Scotland (NHS QIS) and designed to ensure consistency. NHS QIS describe it as:

“[A] record [that] supports a more uniform approach to maternity care in Scotland, and facilitates standardised information collection and documentation. It supports multidisciplinary working and communication of the highest quality. National uptake will promote a seamless delivery of maternity care, regardless of geography, through the sharing of relevant information. Its woman-centred, holistic approach promotes pregnancy and childbirth as normal events.” (NHS Quality Improvement Scotland 2008)

However, this focus on the collecting of information through the initial consultation is arguably flawed in that it relies on the obtaining of information through the asking of questions. That is not to say that the opportunity to offer relevant information is not afforded by the record. A significant amount of space

is given to enable women to contribute to their own maternity record. The important issue here is how women interpret this opportunity and how safe they feel to provide the information. It would be unfair not to acknowledge the attempts to be inclusive in the development of the record as it no longer asks for the husband's or father's name but asks for details about who will be providing support and their relationship to the woman. This offers the opportunity for the woman to identify the non-birth mother as her partner, although it does not in itself eliminate heterosexist assumptions which are evident in other areas of the document. One such assumption is the question for parous women '*is this current pregnancy with a new partner?*' This question is important because it is not asked in the social section but as part of the previous obstetric history. It is deemed to be clinically important because parous women are at risk of pre-eclampsia in the same way as primigravid women if they are pregnant with a different father. This is an issue of genetics. If the woman is lesbian she may or may not have a different partner but the important question for her is whether the pregnancy is using the same genetic 'father' or a different one.

Using neutral language in maternal history-taking is seen as an important way forward in facilitating disclosure (Röndahl et al. 2006). As noted in Chapter Two, Wilton and Kaufmann (2001) found that the booking visit was one of the areas where midwives performed least well in delivering appropriate maternity care for lesbian women. In their study the booking visit was seen to be a time when heteronormative language and expectation were at their highest. Women would

have to make an assessment of whether or not to come out to the midwife when questions asked did not fit with the woman's sense of self.

Findings from Wilton and Kaufmann's (2001) study were used to inform the RCM position paper on care of lesbian mothers (Royal College of Midwives 2004). The advice given to midwives is to recognise difference as being something that applies to all women:

"Appropriate care for lesbian clients is nothing more than woman-centred care. The skills and attitudes required to 'get it right' for lesbian mothers will benefit all women - because all women may have feelings, experiences and issues connected with pregnancy and childbirth that lie outside midwives' expectations and assumptions, and because many women do not fit into the traditional model of expectant parenthood."
(RCM 2004)

Professionally midwifery has approached the issue of lesbian motherhood in a way that does not single out this element of diversity as being in some way unusual. Diversity is viewed as being equivalent to women-centredness and therefore should be accommodated by usual midwifery practice. However, from the evidence it is clear this is still not the case. Indeed, midwives have not been particularly effective in accommodating sexual difference among colleagues with some homophobia reported (Henley-Einion 2005).

Interestingly, one of the main problems with history-taking is that midwives seem unable to document difference where it is identified (Dibley 2009; Røndahl et al. 2009) or leave the woman to make amendments to the documentation through scribbled notes. In cases where women have offered information about their sexual orientation or primary relationship which does not fit with documentation, midwives have become distressed at the idea of modifying standard forms. This links very closely with Hunter's (2004) discussion of emotion work in midwifery. Hunter's (2004) research explored the contexts in which midwives identify the need for emotion work: in other words, where they have to deal with stresses or emotional tensions. Midwives in her study indicated that more tension existed in those environments where they were required to practise in less of a woman-centred way: the *with institution* rather than the *with women* model of midwifery practice. The former approach to midwifery care tends to be exhibited in practice environments where meeting target outcomes is valued and pressure is exerted at the level of the organisation, and in this context midwives are less able to be flexible and accommodate difference. Organisational pressures within maternity care adversely affect its central tenet: woman-centredness. This tension between philosophies or practice is something to which I return within the findings chapters.

Professional interpretations in history-taking contexts

In addition to the issue of heteronormative language is the process of stereotyping or judgment that can be experienced in the therapeutic history-taking interaction. In Røndahl et al.'s (2009) study, participants encountered (or perhaps perceived) embarrassment in the midwife, as well as a sense of disgust in relation to lesbian motherhood. This led, not surprisingly, to distress and a change of professional. Indeed, in a study undertaken by Hinchliff et al (2005), exploring the challenges felt by general practitioners in sexual health encounters with LGBT individuals, embarrassment was identified as a likely response. G.P. respondents indicated that they would avoid asking questions about sexual health in case this highlighted their ignorance about sexual practices among the population. Personal beliefs about minority sexual orientation were also shown to have an impact on clinical history-taking with G.P.s having to learn actively to keep their personal beliefs invisible within the encounter (Hinchliff et al., 2005). The conflict between personal belief and professional practice is evident although when obvious to service users it clearly affects the therapeutic relationship.

Skelton and Matthews (2001) undertook an evaluation of professional development courses designed to support medical practitioners in obtaining sexual health histories. Frank discussions in relation to beliefs about minority sexual orientation, as well as sexual practices generally, and including embarrassment and stereotyping, were undertaken as part of these courses. This

approach to improving practitioner performance in sexual history-taking was seen to be helpful and, equally importantly, acceptable as an approach to professional development. The programmes value as tools for awareness-raising was identified as particularly effective (Skelton and Matthews, 2001). An admission of prejudice or personal belief was the starting point for changing behaviours and accommodating difference in clinical encounters. Recognition of previously unacknowledged personal feelings about minority groups is essential for insight into individual practice.

However, minority sexual orientation and sexual health are not the only aspects of diversity that lead to conflict or stereotyping in therapeutic encounters. In a meta-synthesis of seven research studies relating to information exchange and decision-making in healthcare, Edwards et al. (2009) demonstrated cultural difference as being a barrier to effective care. Cultural difference was seen as leading to cultural assumptions as well as cultural stereotyping, and this in turn led to missed opportunities for effective information exchange or appropriate planning of care. This has obvious implications for patient outcomes. Indeed, medical practitioner demographics have been shown to be surprisingly important in the care prescribed to patients from minority ethnic backgrounds, with lower levels of pain relief as an alarming example (Berger, 2008). An additional finding in this review is that where demographic consistency exists between the patient and the professional, the quality of the patient experience is increased. This is relevant for lesbian mothers accessing maternity care as they

might feel more comfortable disclosing to lesbian health professionals; however fear of homophobia might result in the lesbian health professionals not being out at work (Henley-Einion, 2005; Cant, 2005).

Stereotyping by professionals also impacts on the decisions that they make on behalf of clients, and this is evident across professional groups (McLeish and Oxoby, 2009). Complex social dynamics are apparently at play when professionals make decisions regarding their clients' preferences. Although decision-making is seen to be the remit of the client in modern, consumerist societies, the client can only make the decision based on the options presented. McLeish and Oxoby (2009) suggest that the options presented by doctors to patients vary across gender, age and race because of the stereotyped expectations held by that health professional. Using sets of stereotypes in relation to mental health, Lauber et al (2006) demonstrated that mental health professionals applied more negative stereotypes to their client group than positive ones, reflecting the attitudes of the general population. Holding negative perceptions of a client group suggests an issue with the therapeutic relationship. Distancing personal beliefs is essential for the process of history-taking and professional communication in meeting the individual needs of each person. This extends beyond healthcare into all realms where a professional/client relationship exists. With specific reference to lesbian mothers, if stereotypes exist in relation to minority sexual orientation then, according to this theory, the care options offered might well be based on these.

In order to address cultural difference and the barriers that this produces, improving communication and increasing the evidence base for effective intervention is seen as essential (Panasar and Sheikh, 2006). Improved education, and a recognition that personal belief and stereotypes impacts on the quality of care, are also necessary (Lauber et al., 2006) The concept of cultural competence is part of this move to address professional stereotyping and its impact on history-taking and the therapeutic relationship (Geiger, 2001). Being able to practise with cultural competence means being able to accommodate all diversity in a meaningful way to ensure that health outcomes are improved for all client groups but acknowledgement of personal beliefs must come first.

Conclusion

Chapters Two and Three have given a review of the literature, within the limits set out in Chapter Two, which provides a context for the study itself. It can be seen from the literature review that disclosure is deemed important for physical and psychological health, and that history-taking and information exchange form the basis of assessment in health care. Although the evidence in relation to the health benefits of disclosure is not unequivocal, there is sufficient evidence that there is a relationship between disclosure and improved health outcomes. It is also essential in maternity care if the woman is to experience childbirth in the way that she chooses. Disclosure in health care is also important in establishing

priorities for care, thereby contributing to patient safety. There are both practical and personal reasons for disclosure but the premise of woman-centred care makes this an issue of key importance to midwifery.

It can also be seen that there is a body of literature relating to LGB people's experiences of healthcare generally and lesbian women's experiences of maternity care specifically. This body of research evidence, however, is limited in not exploring the reasons behind decisions to disclose sexual orientation in healthcare contexts. Instead, the research focuses on the outcomes of these disclosures, separating the outcomes from the act of disclosing itself. In this important regard, this doctoral study aimed to focus on disclosure itself: the reasons for it and the factors that facilitate or mediate it. Disclosure of sexual orientation is not a given in any situation but in maternity care, where the focus is on the individual woman and her specific needs, it takes on a particular importance. It is on this aspect of the maternity care experience that this thesis focuses.

Finally, in this chapter it has been shown that the history-taking process itself can be influenced, often unwittingly, by the professional's personal beliefs and the stereotypes they apply to client populations. This impacts on the lesbian mother because openness can potentially lead to assumptions being applied in relation to decision-making.

In Chapter Four the research question and aims are set out. Choice of methodological approach and other methodological issues are considered.

Chapter Four: Methodology and research approach

Introduction

Clearly, before any research can be undertaken there has to be some idea of what is being researched, what questions are being explored, what the anticipated or desired outcomes might be and consideration given to how the question will be addressed. The methodology and methods chosen largely depend on the question being asked and how it can be tested or explored (Silverman 2005). The primary decision for using a quantitative, qualitative or a mixed approach to the research hinges on the purpose of the research and affects all subsequent decisions.

Refining the research question in an exploration of an unknown and unclear phenomenon is not an easy task. Attempting to distil the overall issue into a discrete entity which can be interrogated successfully, at times feels arbitrary and artificial. However, for the purposes of this doctoral study I have turned a broad area of interest – disclosure in pregnancy – into an examinable question. Within this are three overall research aims for the study so that some of the key aspects of this experience can be used as areas to focus upon in data collection and analysis.

This chapter sets out the research question and aims which builds on the justification for the study in the background section, and a discussion of the issues of methodology and method. The chosen methodology is discussed along with an explanation and justification for this choice. The challenge of choosing the most appropriate approach which can accurately represent the views of a group of women, on the margins of maternity care (and society), and to which I do not belong, has been the primary driver in the decision-making process in this stage of the research. There is also a discussion of the ethical issues relating to this research study and the attempts to ensure that participants were protected within, and indeed benefited by, the research. One of the principal likely benefits would be the empowerment of the women through increased visibility and understanding within midwifery; empowerment being one of the primary tenets of women-centred care.

Research question

What are lesbian women's experiences in relation to disclosure of sexual orientation in maternity care contexts?

Research Aims

- To explore the motivation behind and purpose of disclosure of sexual orientation in pregnancy.

- To explore the practical and psychosocial consequences perceived by lesbian women as a result of the decision to disclose.
- To consider the factors that support or moderate disclosure and the circumstances in which it occurs.

An underlying aim of the study was to increase the visibility of lesbian mothers in order to bring them from the margins to the centre of care.

Study design and methodological approach

Qualitative versus quantitative research

The research question informs the methodology underpinning the research project and the methods employed in the process of data collection and analysis (Silverman 2005). The more factual or empirical the research the more structured the research design and approach. Generally speaking, the decision around whether to use a qualitative or quantitative approach is influenced by the intended outcome. For example, an exploration of the number of lesbian women who choose to have a baby or a statistical analysis of the characteristics of women who disclose sexual orientation, versus the number of women who do not, would require a quantitative approach that seeks to answer questions that have been pre-determined and relate to rates of occurrence. Prevalence of pregnancy within the lesbian population is an interesting, and possibly

unknowable, issue. The circumstances within which lesbians become pregnant vary in terms of the underlying relationships (Wilton and Kaufmann 2001). However, that lesbian women choose to become pregnant is a known fact. It is the experience around *disclosing* sexual orientation within that pregnancy which is an issue yet to be explored.

My research question related to the individual *experience* of disclosure and the way this affected the woman, her pregnancy, her partner, the therapeutic relationship with her midwife or GP and her sense of self. The study aim clearly was not about quantity and although it could be approached using quantitative research methods such as a survey or questionnaire, I would argue that the area is not yet well enough understood to be explored using such an objective method. The question and aims, as far as they relate to subjective experience, are far better served with exploratory methodologies, although Silverman (2005) makes the point that often there is no easy distinction between qualitative and quantitative research, and a study could contain elements of both. This study was about each woman's disclosure story. It was unique to the woman because it was *her* story which she constructed for herself. It was not about volume but about depth. Using a qualitative approach was appropriate for exploring experiences in this way (Patton 2002).

However, determining the broad methodological approach is only the first step in deciding how to manage the data – how to collect it, analyse it, understand it

and interpret it. Qualitative research is not a homogeneous entity but described by Denzin and Lincoln (2005, p.2) as a “field of inquiry in its own right... [with a] complex, interconnected family of terms, concepts and assumptions”. It is necessary to clarify the particular set of concepts and assumptions that were applied within the context of this study in order to ensure it was congruent with the interpretations that were made and the conclusions that were drawn (Denzin and Lincoln 2005).

Denzin and Lincoln (2005) provide a broad definition of qualitative research while acknowledging that it is too complex an approach to be defined narrowly. For them it is a research approach that utilises methods that produce a set of interpretive representations of the world as experienced by the participants (Denzin and Lincoln 2005). Thus, qualitative research is part of an interpretivist tradition.

Interpretivism refers to the group of philosophical approaches that value and study subjectivity, experience, individual interpretation, negotiated meaning and social dynamics (Schwandt 2000). Qualitative methodologies acknowledge that reality is constructed at either an individual or social level, and that this reality will differ across groups, between individuals and even within the same individual over time. Meaning is interpreted and the event under scrutiny is processed and assimilated through the contemplation process involved in describing the event (Patton 2002). In other words, the individual might well

make sense of the event or the subject under examination by the very fact of being asked to describe their experiences of it. In contrast (generally speaking) to positivistic research methods such as surveys and randomised controlled trials which strive to describe reality and fact, qualitative research 'celebrates' difference and values outliers and unusual cases, or what might be described as 'deviant cases' (Silverman 2005). Unstructured interviews, narratives, dialogues, participant observation and ethnographies are all methods which allow the participants to interpret their own world rather than have it interpreted for them, in advance, by the researcher. How the researcher interprets and extrapolates meaning from the data is a different matter and shall be dealt with later.

There are a number of methodological approaches that could be used within qualitative research but it has to be recognised that in their 'pure' form these are often philosophical concepts and their elements need to be adjusted or diluted to meet the needs of research. A number of possible perspectives lent themselves to this study; phenomenology, social constructionism and hermeneutics being some examples. Phenomenology seeks to explore experiences and how individuals construct meaning for what they experience (Gubrium and Holstein 2000). Husserlian phenomenology attempts to describe the phenomenon and its very essence, and to describe something which is concrete and definable (Husserl 1990). Heideggerian, interpretive phenomenology on the other hand explores the phenomenon and what it means

for the individual and how their reality is constructed (Heidegger 1996). To this extent this approach fitted well with my research question. The research question certainly aimed to explore experiences or to try to establish the important aspects of decision-making processes for disclosure of sexual orientation in pregnancy. However in this study the issue of social construction, social interaction and cognitive process are also important. My intention was to approach disclosure of sexual orientation in pregnancy as a socially constructed episode in lesbian women's lives – not only in the way that women constructed the experience but the social contexts that influence the way the experience is described and explained. What were the social contexts that made disclosure of sexual orientation a 'problem' (as opposed to a taken for granted part of the process) and how did women make decisions around disclosure in particular social worlds? Therefore, a social constructionist approach might be preferable in that it situates the experience in the social context, attempting to identify those factors which influence the individual perception of the experience being explored (Patton 2002; Dickins 2004).

Brickell (2006), in a discussion on social constructionism in gender and sexuality, argues that social constructionism has become a reductionist umbrella term used within a range of quite diverse disciplines as a way of studying phenomena within them but has not been addressed or interrogated as an entity in itself. To counter this, it is argued that social constructionism is actually a complex and pluralistic approach to explaining the social world (Brickell 2006). Regardless of

its complexity, important in all its uses is the recognition that meaning is created through social interaction, language, and experience (Dickins 2004). Nothing has meaning in and of itself but derives meaning by virtue of being understood by the 'actors' within the experience or narrative that 'tells it'. This quality within social constructionism is useful because the experience of 'the pregnant lesbian' is not one that exists because it has not been widely explored, nor is it homogeneous. It is socially situated, individual and diverse, as are all experiences of pregnancy.

However, using social constructionism by itself lacks a dimension in relation to the position of lesbian women within dominant heteronormative society. Given the continued gender inequalities prevalent within many societies and cultures, lesbian women, relatively invisible within their pregnancy, could be said to occupy an even more unequal position. The fact that society is understood according to the dominant norms within it (Harding 2004) means that any research, including that using social constructionism, is at risk of reproducing inequalities. A framework capable of dealing with this dominance and promoting the perspective of the 'other' is important for this research. This is where the importance of an inclusive approach and the use of hermeneutic phenomenology comes into play and will be discussed next.

Hermeneutic Phenomenology

Developing a useful understanding of hermeneutic phenomenology is challenging because there is a great deal of literature relating to it and much of it uses terms interchangeably in a very unhelpful way. Hermeneutics exists as an approach, and phenomenology also exists. However, many commentators will use the term descriptive phenomenology to indicate Husserl's approach (straight forward enough) but use interpretive phenomenology and hermeneutic phenomenology equally to mean Heideggerian approaches to this branch of philosophy. And while Gadamer was a pupil of Heidegger, his phenomenology is not the same as Heidegger's.

Hermeneutic phenomenology is an exploration of and an attempt to understand a phenomenon through an analysis of text. Although *Hermeneutics* was originally associated with analysis of existing written texts, in particular the Bible, its subsequent association with phenomenology has led to a broadening of this definition to incorporate texts however derived, for example through narrative interviews (Patton 2002). This made it acceptable here where unstructured narrative interviews were the method of data collection.

Hermeneutic phenomenology has been used increasingly in nursing and midwifery research in recent years and nurse researchers have been criticised for using phenomenology and other philosophical approaches poorly or even

misrepresenting their use (Paley 1998; Paley 2005). This comes from a lack of understanding of the more complex philosophical elements such as bracketing and essences. Attempts have been made within nursing and midwifery to develop research methods deriving specifically from the work of the main two hermeneutic phenomenology philosophers, Paul Ricoeur and Hans-Georg Gadamer, as a way of ensuring rigour in their use and admitting that what is done in the name of research and what is done in the name of philosophy are not neatly transferable (Fleming et al. 2003; Lindseth and Norberg 2004).

Gadamer's phenomenology

Gadamer wrote the first edition of his key text *Truth and Method* in 1960 although the first English translation was of the second edition in 1975. His philosophy is a direct derivation of Heidegger's phenomenology and its primary focus on *Dasein* (discussed below). Gadamer's definition of hermeneutics and phenomenology appears to be the way that phenomena and *Dasein* are understood across time and space. He states that the way he uses the word 'hermeneutics' is in the way that it:

"denotes the basic being-in-motion of Dasein that constitutes its finitude and historicity, and hence embraces the whole of its experience of the world. Not caprice, or even elaboration, of a single aspect, but the nature of the thing itself makes the movement of understanding comprehensive and universal" (Gadamer 2004, p.xxvii).

It appears to be a way of looking at a phenomenon and understanding it in its own terms regardless of time and place.

Fleming et al. (2003) developed a method from the hermeneutic phenomenology of Gadamer for use in nursing research. They did so using the original German texts rather than relying on translated texts in an attempt to improve the authenticity of their method. The method of data analysis is very similar to that developed from Ricoeur's work for example (Lindseth and Norberg 2004) but goes further in the way it uses Gadamer's philosophy to inform understanding and interpretation of data. Fleming et al. (2003) offer a four stage approach. This is not a sequential process but is flexible in its approach depending on the needs of the data.

The first stage is to gain an initial understanding of the meaning of the dialogues. This initial understanding is influenced by the pre-understandings of the researcher who has a certain expectation about what he or she will find. Fleming et al. (2003) describe this as *gaining understanding through dialogue with texts*. 'Text' is defined broadly to include the dialogue collected through interviews.

The second stage is a structural analysis and the search for meaning units. These meaning units must always be reflected on the research question and the area under scrutiny in order to determine meaning and the way the meaning relates

to the question. These units of meaning are then developed into themes and are subjected to the pre-understandings of the researcher which also influence them.

The elements of meaning are then referred back to the original meaning of the initial understandings so that the meaning of the whole is expanded through the understanding of the meaning of the parts. This is an iterative process which employs the *hermeneutic circle* which is essential for Gadamer. This is a process where meaning derives from the phenomenon itself, the participant, the researcher and the researcher's pre-understandings. This can also be described as a process whereby the understanding of the individual and the understanding of the researcher work together to produce a more complete understanding or meaning. The meaning given to the narrative data can change over time. In fact it changes every time it is revisited (Patton 2002). The interpreted meaning from both perspectives alters as data analysis continues, is a potentially endless process and is one that is based on consensus (Fleming et al. 2003). A point considered by the researcher to be the final meaning might be arrived at purely for pragmatic reasons such as time constraints and the reality and applicability or usefulness of the research.

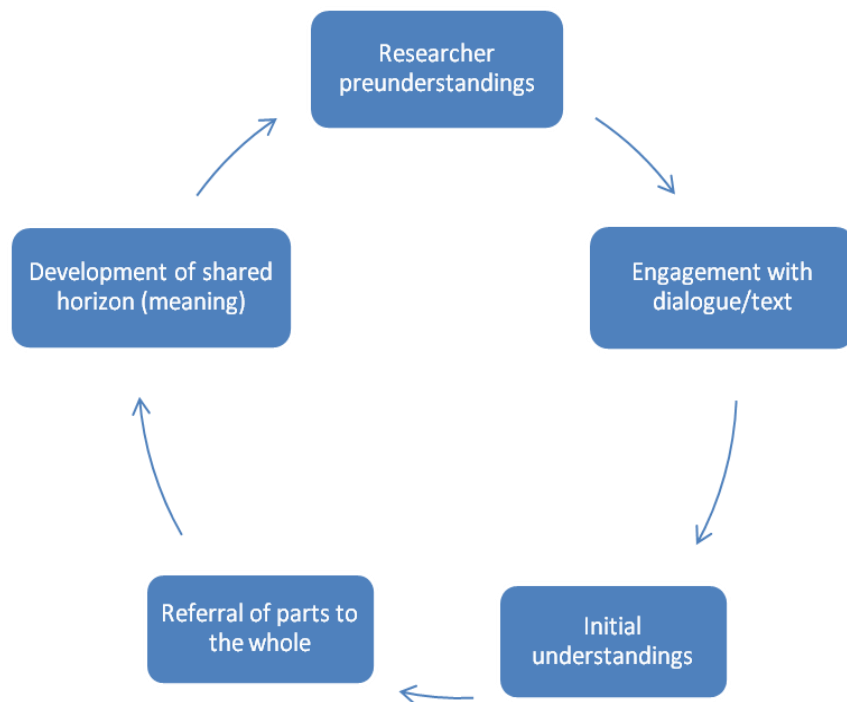
The final stage is about identifying specific examples from the text which appear to represent best the shared meaning of the text. These are similar to the

concept of paradigm cases described elsewhere in phenomenological research (Benner 1994).

Hermeneutic phenomenology requires a reflexive approach rather than a bracketed approach of preconceptions. In addition to this Gadamer (2004, p.301) uses the phrase *fusion of horizons* (Gadamer 2004) to describe how the meaning that the participant places on their experience (their horizon) and the meaning interpreted by the researcher influenced by their pre-understandings (their horizon) come together to produce a new horizon (new understanding of meaning). The researcher must be able to identify his or her horizons and then attempt to see beyond these thereby making the fusion of horizons possible. If this process is conducted with transparency then it shows how meaning was derived.

The research process using the hermeneutic circle can be represented using two cyclical diagrams although the process is actually one endless cycle. The dynamic process of moving from naïveté to development of shared meaning is illustrated by the move from the hermeneutic circle (initial stage) to the hermeneutic circle (iterative stage). The starting point of the analytical process is the identification of pre-understandings which inform the engagement with the interviews as dialogues followed by the forming of an impression of meaning (initial understandings).

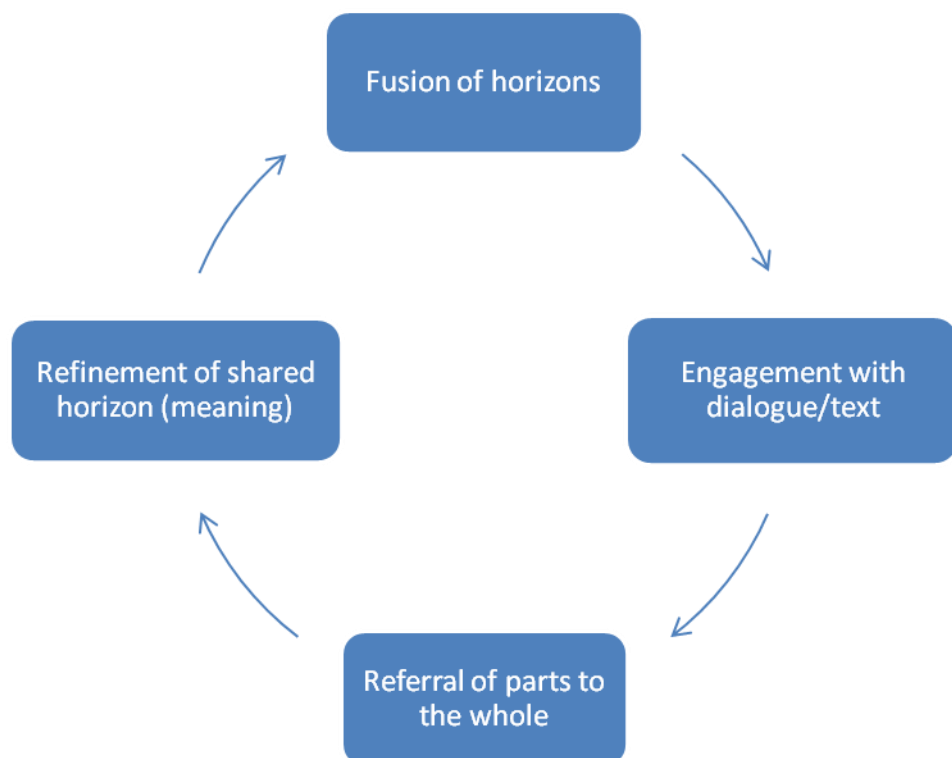
Figure 2: Gadamer's hermeneutic circle (initial stage)



In the iterative stage of the process the developing shared horizons inform the continued engagement with the texts and the referral of the parts to the whole, with a refinement of the shared meaning or fused horizons. Although this is not two separate processes it is difficult to represent the hermeneutic circle within

this method without making this hypothetical separation. In reality the processes are continuous and potentially unending.

Figure 3: Gadamer's hermeneutic circle (iterative stage)



In addition to the role of the hermeneutic circle in Gadamer's work, the emphasis on the concept of *historicity* is also what makes this an appealing approach. Gadamer's philosophy relies heavily on this concept which is in some ways similar to the idea of social construction (Gadamer 2004). *Historicity* is the

way that meaning of a phenomenon relates to its historical context and can be understood more completely in that way. Gadamer (2004) argues that understandings are applied in a way that acknowledges the context of the phenomenon and not the context within which it is viewed. This means that the event is not viewed in history and interpreted in the present but an attempt is made to understand it in its historical context. The recognition that meaning is contextually and historically derived is important when attempting to interpret an experience that is not ours. This is also important, and useful, when undertaking research that explores an episode from the past that is now being reflected upon, as was the case in this doctoral study.

Gadamer sought to expand Heidegger's philosophy and the concept of *Dasein* or 'being in the world'. This seems to be what phenomenological researchers refer to when using the common expression 'lived experience'. This does not appear to me to be interchangeable in this way. The expression 'lived experience' seems to be a clumsy way of expressing what was intended by Heidegger. My understanding of what I am exploring is more akin to women's experiences of *being* lesbian and pregnant although this must then be contextualised within the concept of disclosure.

I was clear on why hermeneutic phenomenology fitted with my research and why I believed it was the best methodological approach for this study. Part of this was the fact that it enabled me to acknowledge my pre-understandings, use

an approach that avoided structured assumptions and I needed to identify an approach which would work with narrative data. The decision around whose approach to use in terms of the research methods was also one of relevance to some extent. Gadamer's work is well developed in healthcare research. It also specifically addresses key aspects such as pre-understandings, historicity (I was after all asking the women to reflect on past experiences in a changing social and legal environment) and narrative data. Using this approach explicitly enabled me to seek the meaning of the phenomenon both in the narratives of the participants and my own pre-understandings. The pursuit of the fused horizon that resulted as the shared meaning of the issue of disclosure was the purpose of the study. At the end of the day I am not a philosopher and I was not aiming to expand an area of philosophy. I used a research methodology which derived from a particular philosophical tradition and provided me with the necessary lens through which to explore my data and answer my research question.

Taking an inclusive approach

One of the premises on which this study was based was that of the invisibility of lesbian mothers. Their relative lack of visibility in maternity care has the effect of pushing them to the margins of care rather than of including them as the focus of mainstream midwifery. In this context, they are a group on the margins although not necessarily marginalised. Researching experiences in the lives of groups of individuals on the margins required a research approach that was sensitive to the influences (for example, power, culture, structure) that make

that group marginal (Sprague 2005). A feminist lens is one that can be employed in an attempt to address the inevitable power relationships between the researcher and the researched, particularly when researching the experiences of women (Naples 2003). When more marginal individuals, such as lesbians within maternity services, are involved in research the sensitivity to power relationships might arguably be greater. This is particularly true when, as in this case, the researcher does not belong to the marginalised group. Although feminist research is frequently described in loose terms as research by women for women it is much more than that. Feminist research explores those aspects of life where power relationships exist and where the perspective of one group is suppressed by the more powerful perspective of another. It could be used to explore the impact of race, employment, disability and many other factors. Its obligation to redress imbalances in power makes it an important approach in considering research into any disenfranchised group (Olesen 2005). In clarifying this position, Sprague (2005) asserts that many of the social structures that subject women to inequalities function to control other social groups such as the poor and ethnic minorities.

Theories using standpoint approaches (those approaches which privilege the standpoint of oppressed groups), would argue that there is no homogeneity in the oppression of groups, even when a particular group appears homogeneous. For example, the experiences of women vary enormously depending on their own lives and place in the world (Harding 2004). There is no one single oppressor

and standpoint theory has moved on from Marxist notions of bipartite society. So the research design in this case does not put forward its own singular position but aims to be flexible enough to accommodate variation instead of predicting a uniform perspective. In other words, the method privileges the perspective of the participant rather than imposes its own agenda (Haraway 2004).

The use of feminism and inclusion here is not to achieve a particular political end but to develop and use a research method that is sensitive to power relationships and acknowledges them. The overall aim is to ensure that as far as possible the data analysis represents the reality of the women and does not impose current and dominant hegemonic positions. As Harding (2004) points out, this is not simply a case of making the research method ostensibly value-neutral because that would only hide the factors that marginalise social groups.

The underlying aim of this study was to make the experiences of lesbian women visible in maternity care. Its purpose was to make visible the experience of childbearing lesbians and to mainstream this aspect of their lives. Enabling women to tell their stories of disclosure of sexual orientation in pregnancy provides an opportunity to explore the different realities of those stories and attempt to define the concepts.

Chapter Five: Methods and research process

Introduction

In Chapter Four I discussed the theoretical and methodological issues relating to the study, as well as setting out the principles of the chosen research method. In this Chapter I aim to discuss the method and process in detail, with the actual steps that were taken in conducting the study. A number of methodological challenges arose and these will be discussed along with a justification for the decisions that were made for each challenge.

Answering the question

The focus of this study was how women make decisions around disclosure of sexual orientation in maternity care contexts and how they experienced this disclosure. Without anticipating the findings or the recommendations it was not the aim of this research to add to the list of questions already asked of pregnant women during the booking and antenatal period. Instead it was hoped that the findings of this research could be used to improve the way that information is obtained through history-taking and women-led disclosure is facilitated.

Identifying a study population

Decisions around the study population are of key importance in ensuring the quality of the research and relevance of the findings. Identifying a group of individuals who can represent a phenomenon at some level is a fundamental

part of answering any research question, whether it is qualitative or quantitative in its approach. In hermeneutic phenomenology, as with other types of phenomenology, there is a phenomenon to be explored and it is essential to identify what this is and to do so unambiguously (Denzin and Lincoln 2005). In the case of this research the phenomenon was *disclosure*. More specifically, it was the disclosure of a particular invisible factor of personal relevance (sexual orientation) for women. So it was actually **the disclosure of** rather than **the having of** an invisible factor of personal relevance (labelled by Chaudoir and Fisher (2010, p.236) as ‘a concealable stigmatised identity’) that was being explored. The challenge was to identify a group of individuals who could shed light on the experience of disclosure in a way that illuminated the area under scrutiny because this was not a question with measurable outcomes (Laverty 2003). In the context of this study, I have had to make decisions about how best to achieve the furthering of the research question. Sometimes these decisions have been purely methodological and sometimes they have been pragmatic.

The research question could have been interrogated in two ways. The first was to explore the experiences of any woman who has had a pregnancy and to ask them if there were invisible factors of personal relevance for them and what was their experience of disclosing or not disclosing these factors. Although this would have facilitated a broad interpretation and exploration of the concept of ‘invisible factors of personal relevance’ it would potentially have led to an incoherent discussion and analysis because the factors could have been diverse

beyond categorisation. Sampling would also have been very difficult to co-ordinate as the concept of factors of personal relevance would be open to interpretation as this is an undefined area.

The second was to take an individual factor, already identified as being of personal significance, and to explore the disclosure or non-disclosure experiences of women who had this factor in common within pregnancy. That way a more coherent analysis could be undertaken because there was a common thread.

In order to explore this concept of invisible factors of personal relevance and the phenomenon of disclosure it seemed appropriate to attempt to identify a paradigm case, and this was discussed in Chapter One. As discussed, for the purposes of this study I identified the client group of lesbian women. I considered this to be a unique group of women because they appeared to be the only group whose 'factors of personal relevance' actually ran counter to the physiological presumption of heterosexuality that underpins human reproduction. The issue of sexual orientation has a particular quality in relation to pregnancy although the same could be said of the presumption of fertility: if you are pregnant then you are fertile. However, fertility status and the utilisation of reproductive technologies in pregnancy is an area which is explicitly part of the history-taking aspect of maternity care. I considered other aspects which also fell into this explicit area of history-taking: race, ethnicity, domestic abuse,

infertility, marital status, substance use or misuse, disability and other personally relevant factors. However, all of these already inform the antenatal booking process.

Lesbian women represent a valuable group of participants for two reasons. Firstly, the issue of sexual orientation creates a discrete group (although not a homogeneous one) which is identifiable and which can be accessed in the numbers that can be useful for research. Although the group is not entirely homogeneous and the experiences will not be the same, the actual issue under scrutiny - that of not being heterosexual - is the same for each participant (although experienced differently). In addition to this, the importance of disclosure of sexual orientation already has a strong evidential basis particularly in healthcare (Cole et al. 1996; Salmon and Hall 1999; Wilton and Kaufmann 2001; Markowe 2002). The concept of 'coming out' is well developed and provides strong justification for its application to maternity care. This study was not exploring the consequences but the *experience* of coming out in a particular context.

Early in the doctoral process I did spend considerable time exploring sex workers as a possible study population. This group of women regularly access maternity services and would have to disclose their occupation for it to be known. The issues of sexual health outcomes for sex workers as well as contraceptive advice, alcohol and drug use or misuse, and pregnancy as a consequence of sex with a

client were all important issues which would impact on the woman's overall health and wellbeing. While this group of women offered great potential as a study population in the end they were not included as it was anticipated that their experiences and needs would be so different from those of lesbian mothers that it was deemed too complex to include both groups of women.

Study population and sampling

The study population for this research was a marginalised minority group and therefore likely to be small in number and potentially hard to access. As discussed in Chapter One, estimates of the prevalence of homosexuality currently range from 6 (UK Treasury 2005) to 10% of the population (Kinsey 1948; Kinsey 1953) although the 6% figure is being used for the purposes of this study. It is not possible to ascertain what proportion of lesbian women decide to have children (Wilton and Kaufmann 2001) but given that rates of pregnancy in the heterosexual population are falling and that it is less straight forward for lesbian women to become pregnant in the first place, then it is probably safe to say that the numbers are fairly small. However, the potential implications for developing more effective approaches to facilitating woman-centred care make this a useful and viable research project designed to enhance midwifery care.

Patton (2002, p.230) suggests that sampling in qualitative research is generally considered to be purposeful in that the aim is to choose a specific population from which to obtain specific data. Rather than large samples the aim is to obtain

a sample of 'information-rich cases', chosen because they are capable of providing insight into the issue under scrutiny. Patton (2002) described a number of approaches to purposeful sampling but the most appropriate for this study is discussed and justified next.

The sampling frame originally used non-probability criteria sampling which, by necessity, consisted of lesbian women who had undergone at least one pregnancy. This is broad in terms of inclusion criteria and ideally all women who fit within these criteria would be eligible for inclusion in the study. Feminist research, particularly that which involves groups of women from outside the mainstream, should be inclusive and provide an opportunity for all the women within that group to participate in research (Olesen 2000). However, there were considerations applied to meet the pragmatic needs of the research and also to protect the participants. These have been termed *cautionary considerations* rather than exclusion criteria because, while the possible issues related to them should be made explicit, the decision to participate or not should have remained with each individual woman. Indeed, there is a sense in which it is arrogant of any researcher to decide who may participate and who may not when the participants themselves retain a significant degree of power in their decisions to respond or not respond, to give or withhold the answers to the questions the researcher asks (Naples 2003). An important part of this study is to give a voice to a somewhat muted minority (Sprague 2005) rather than to cause additional stress, and if women were free to make the decision to participate in the study

then this was sufficient grounds for their inclusion within it. With this underpinning inclusive philosophy in mind, the considerations noted below were broadly interpreted, and were used as a way of enabling women to make an informed decision about their participation.

Inclusion criteria

Lesbian women who have undergone at least one pregnancy and are not currently in their first pregnancy: Initially the intention was for the inclusion criterion to state that the women must have undergone at least one full term pregnancy. The rationale for this was that each woman within the study population would have accessed antenatal, intrapartum and postnatal care; in other words each of the individual elements of maternity care. This would also have helped to ensure that most of the women included in the study had encountered a range of health professionals within their experience of maternity care and this is a central condition within the study. However, on further consideration it was felt that this would actually exclude an even less visible group of women, this being those women who are lesbian and who have suffered a pregnancy loss or pre-term birth. These particular women would necessarily encounter a different set of experiences within the maternity care services and in a time of crisis during which their relationship with significant others becomes important in different ways.

Maternity care provision is very sensitive to the needs of women and their partners in times of higher stress such as pregnancy loss, but seeking the experiences of lesbian women at these times is important in order to get a complete perspective. The research question related to lesbian women's experiences of disclosing sexual orientation in pregnancy and to insist on a full term pregnancy would be to exclude, inappropriately, women from the study. The only useful limiting factor that could have been applied here was that the woman must have formalised the pregnancy by accessing some element of the maternity care services.

This broad inclusion criterion, however, required that the women who were currently in their first pregnancy would not be included in the study. This could potentially have had a negative impact on the way they experienced or perceived the rest of their pregnancy, having no other experience on which to draw. It could be considered unethical to include this group of women and this will be discussed further.

The use of formally identified exclusion criteria within the study was avoided. My desire to use an underlying feminist philosophy meant that being inclusive was the key to avoiding a paternalistic approach. Applying strict exclusion criteria seemed to be a direct contradiction of the approach being asserted. Using the inclusion criteria and cautionary considerations outlined in this chapter, preliminary discussion with potential participants determined which women

wished to be included and which did not. This was a negotiated process where the participants were given the opportunity to decide their level of participation for themselves. The extent to which this sample profile remained throughout the study is an issue to which I will return as the need for flexibility arose, specifically in relation to Daryl, as a feature of the chosen methodology.

Cautionary considerations

Lesbian women whose only experience of pregnancy was within an ostensibly heterosexual relationship: A significant number of lesbian women have their children within marriage or other heterosexual relationships (Saffron 2001). Although the women may have known themselves to be lesbian at that time they would be unlikely to disclose this fact to their midwives or others, although such a disclosure is a possibility. This is a consideration because this group of women is also less likely to have disclosed their sexual orientation to their (male) partner at the time of the pregnancy. The pregnancy would have been to all intents and purposes the result of a heterosexual relationship and the issue of 'coming out' to a heterosexual partner was not explicitly part of this research study. However, that argument involves assumptions on my part and women in this situation who wished to participate in the study would not necessarily have been excluded if they had felt their experiences were relevant to the research aim.

Lesbian women whose most recent pregnancy was more than 5 years ago: The length of time since the pregnancy was taken into consideration on the basis that recall can be challenging after extensive periods of time and that the researcher who intends to use interviews should consider the 'stability' of the data produced (Elliott 2005b). This was an attempt to ensure a degree of trustworthiness in the data collected. However, the time factor was also important in that it reflects changes in the way that homosexual relationships were viewed in a changing context, socially and legally (Jacoby and Cartwright 1990). There was no intention for the study to be comparative but the issue of recall is personal and individual. There is some evidence that women are reliable sources of information in relation to the childbirth experience but that their opinions and feelings relating to those experiences may change over time (Jacoby and Cartwright 1990). Limiting the length of time between the event and the data collection ostensibly minimises uncertainties in recall but it is arguable that decisions regarding the actual length of time acceptable will always be arbitrary. In inclusive research it should be up to the individual woman to make an assessment about her memory of events. If narrative interviewing is considered a valid way of collecting data for qualitative research (Patton 2002; Elliott 2005b) then the issue of time should not be problematised. Telling a life story does, after all, take a life time.

Lesbian women who are younger than 18 years of age at the time of the research: The inclusion of this presumably small group of potential participants

was treated with caution because this is a more vulnerable group of young women who may have complex issues relating to their sexual identity. In addition to this are factors relating to undergoing pregnancy as teenagers such as loss of schooling, family tensions, lone parenting and decisions around termination or adoption. Eighteen may seem an arbitrary age and to some extent it is, however, it is also the age at which a civil partnership can be entered into without parental consent so there is some basis in law for this age limit being applied. Women under the age of 16 would be excluded from the study. Fundamentally, however, an age limit is a cautionary consideration aimed at protecting the individual. There would have been no exclusion of women who were under 18 at the time of their pregnancy but who were over 18 at the time of the interview.

Women for whom English was not a first language: The data collection method for this study was narrative-based; therefore the issue of language was an important one. Although the research philosophy was one of inclusion rather than exclusion, the commonsense approach would be to exclude women for whom English was not a first language. An alternative approach would have been to assess women's levels of spoken English when approaching them for consent. If a woman felt able to make herself understood then she should not have been automatically excluded. The pragmatic issue of my first language being English was also an important consideration. Although respondent validation was not used extensively in this study, if it had it would have been heavily dependent on

the level of understanding of written English of each woman. In addition to this, English is the only language that I speak or read fluently. There was no funding for the services of a professional interpreter or translator, and the collection of data, no matter which method was used, would be problematic if the woman did not speak English. Again this would have been a negotiated participation based on the actual ability of the researcher and participant to understand each other, had the need arisen.

Accessing participants

There is no doubt that accessing a group of individuals who are interesting because of their invisibility presents certain challenges. How does the researcher find participants who do not want to be found within everyday life? One way to do this is through existing structures which support marginalised groups (Dalla 2002). There are support groups such as Pink Parents and Stonewall where the members will have disclosed their status as lesbian mothers. However, this would have been a self selecting group who were possibly more likely to have disclosed their sexual orientation anyway. Women who were not members of such groups were an important part of this study. Identifying and contacting a study population a number of whom will have chosen to remain invisible or anonymous was potentially very difficult. However, only intending to include those women who had disclosed or who live within a set of organised support structures would have meant that the important issue of non-disclosure of

sexual orientation would be missing within the study. My intention was for this study to be as inclusive as possible and to obtain data relating to as wide a range of experiences as possible. So the most invisible women within the potential study population had to be accessed where possible. In reality, those women who had not disclosed their sexual orientation when accessing maternity care did not agree to participate in the study. This was always a risk but it was ultimately through individual choice and not through being deliberately excluded.

In order to achieve this level of access recruitment of participants was undertaken through a process of snowballing. The snowball method of sampling is a useful technique when trying to identify and access key informants (Patton 2002), in other words those individuals who can contribute vital content to the overall data set. It is a method of purposeful, non-probability sampling, appropriate for qualitative research seeking to explore the experiences of individuals with a particular set of circumstances. Using contacts within the LGB communities initially in, but not limited to, Scotland it was hoped that women who did not disclose sexual orientation in pregnancy but who were willing to participate in the study would be identified and approached through a third party (Blaxter et al. 2001; Dalla 2002). Such third parties may be other study participants but might also be identified through the wider LGB community.

This study proposed a feminist influence to data collection and analysis, an approach that can be described as research *for* women *by* women but is also a useful approach to use when dealing with issues of inequality or marginalisation (Naples 2003). It was hoped that the inclusive and potentially emancipatory (in that it makes visible within maternity care an otherwise hidden group of women) nature of the study would ensure that potential participants viewed participation as positive. However, it must be recognised that the study aimed to explore very personal aspects of these women's experiences, therefore there was always a risk that women would not agree to participate because they might consider the research to be too intrusive. There was a risk that participants would feel objectified by the research (Sprague 2005), particularly considering the voyeuristic attitudes of heterosexual society towards female same sex relationships, or more specifically lesbian sexual activity.

The study population is discussed in detail in the section entitled *Study Participants*.

Data collection and generation

Interviewing

In common with a range of qualitative approaches the data collection method chosen was a form of unstructured, narrative interviewing. This is a widely accepted form of data collection despite its subjective nature (Alldred and Gillies

2002). Silverman (2002) argues that interviewing is the best way to obtain information that we cannot see and observe. However, he also suggests that as a method of data collection interviewing is at risk of losing some of its credibility because it is a technique that is overused in popular culture. It is also a method that relies on the interviewees telling the truth (or their interpretation of it) or being accurate in what they say and some consistency in the interpretation by the interviewee (Aldred and Gillies 2002). Interviewing is an important and useful data collection method that requires skill to optimise results. Simply knowing what it is does not mean knowing how to do it well (Oakley 1981). It is not an objective way of obtaining information but requires skill to ensure that data is useful and interesting in terms of the research question (Elliott 2005b). Reflections in relation to the interviews are offered in the limitations section in Chapter Nine.

Data were collected using an unstructured form of interviewing incorporating dialogue and narratives. This narrative approach is described as a conversation that involves both the participant and the researcher (Blaxter et al. 2001). It is the conversation that produces the data rather than simply the responses to questions and, in relation to hermeneutic phenomenology, is described by Fleming et al. (2003 p.117) as “gaining understanding through dialogue with participants”. This phrase is used as an attempt to express the interactive and dialogical nature of the unstructured interview. The interview is a conversation where understandings are developed. This approach was chosen in the hope of

avoiding assumptions within the research because there are already many assumptions relating to the experiences of LGB people in general. For example, it might be assumed that the lesbian experience of disclosure will be a negative one or one in which the woman is fearful. It is also an assumption to suggest that disclosure of sexual orientation is important or necessary, or that being free to disclose improves experiences or pregnancy.

The women were asked to participate initially in one interview where they were given the opportunity to tell the story of their maternity care experiences, particularly in relation to their decision to disclose - or not - their sexual orientation. A trigger question - *'Tell me about your experiences of being lesbian and being pregnant'* - was used to facilitate the process and direct the narratives in a meaningful way (Torrönen 2002). The participant information sheet also provided detail in relation to the purpose and focus of the study to inform the direction of the interviews (see Appendix II). Although feminist research is about inclusion and autonomy for the women involved, the data collected has to be useable for the purpose intended so if a trigger was to be used it had to direct the response towards the research question. In other words, it was a generative question (Flick 1998). Women are generally very keen to talk about their childbirth and pregnancy experiences and birth stories are a very real part of everyday life (Pollock 1999).

The very nature of unstructured interviews made it impossible to establish in advance how long each one would take. Indeed, it is arguable that the length of interviews should be led by the participants and what they wish to say in order that the data obtained is as rich as possible. Elliott (2005b) argues that, taken to its logical conclusion, narrative interviewing could take up to six hours but that a reasonable data set can be obtained within 90 minutes to two hours. She suggests a policy of telling interviewees that the interviews are likely to take an hour and a half which ensures that participants have some idea what to expect but that the format can remain flexible. In participant-led unstructured interviews the process can be considered therapeutic with an agenda that derives from the individual and the content remaining fluid (Peel et al. 2006). In fact, the interviews lasted between 34 and 56 minutes. This was shorter than I had anticipated but the conversations ran their course within these time frames. This can also be seen as being positive because I was comfortable that the dialogues were relevant to the research question.

The feminist perspective in data collection for this study is not unique in forcing the researcher to consider implications beyond those of length of interview. Because social relationships and norms are constructed from those of the dominant group the interaction between interviewer and interviewee tends to adopt these normative relationships (Alldred and Gillies 2002). This is partly because individuals who do not know each other but who have to form some kind of relationship within a short space of time will tend to adopt the roles

implicit within social structures. Put simply, the interviewer will ask questions and the interviewee will respond in the way that she or he anticipates is the expected 'right way' (Naples 2003; Elliott 2005b). This 'skews', to use a quantitative term, the data in favour of social norms and does not necessarily take account of how these norms influence experiences. In order to counteract such normative responses, it was necessary to use a method of data collection that promoted a reconfiguring of the interviewer/interviewee dyad. The unstructured interviews achieved this but the shorter than anticipated length of the interviews, I feel, was a consequence of this approach.

Ethical issues

Any research, social, medical or otherwise, that involves human participants (and animals for that matter) will require ethical approval from a formal body representing the interests of the participant groups (Edwards and Mauthner 2005). In order for the ethics committee to make an informed decision about granting ethical approval the research project must be clear and the purpose, methodology and methods explicit (Richards 2005). The potential benefit to the participants and the steps taken to protect them should also be robust.

There are ethical issues in every research study and these relate to the aim of the research, the research question, the study population and the data collection and analysis methods. Ethics in research has become delineated by a set of

apparently common-sense considerations that are borne in mind by the researcher but which are necessarily embedded in pure philosophical ethical theory. Kvale (1996) identifies three ethical models from which all ethical considerations in research can be derived: duty of ethics principles, utilitarian ethics of consequences and virtue ethics of skills.

Deontological or duty-driven ethics is associated with Kant and asserts that there are universal rights and duties that underpin human action, including research. Principles such as honesty, justice and non-maleficence/beneficence inhabit the deontological stance and the underpinning belief is that there are some things that can never be justified because they fundamentally run counter to these principles (Kvale, 1996). This is in many respects a theological position where the impact on others of the action of an individual or group are necessarily permitted or prohibited through an underlying moral position. In terms of this study, the duty-driven ethical approach ensures that the needs of all of the participants as individuals are taken into account. The implications of participation in the study are addressed at an individual level rather than a population or consequence level. This means that when using this approach the participants are free to participate or not and that this freedom or autonomy endures throughout the research cycle.

Consequentialist or utilitarian ethics denies that there is an absolute right or wrong but the action is acceptable or unacceptable on the basis of its

consequences and outcomes. This ethical standpoint is associated with Jeremy Bentham and John Stuart Mill in the 18th and 19th centuries. Bentham believed that actions were permissible on the grounds that they fulfilled the human need to increase pleasure (Bentham 1781 (2000); Harris 1997). His belief was that people are motivated by the desire to increase pleasure and reduce pain and that any action taken should be weighed against this principle. An action could be considered ethical or moral if its consequence was to increase the overall pleasure of all the members of a community to a greater extent than it increased their pain. This is a psychological argument and would fit well with Freud's *pleasure/unpleasure*³ principle (Freud 2003) but it is also a somewhat superficial and arithmetical approach to ethics. The principles of utilitarianism were later modified by Mill in 1861 (Mill 1861 (2001)) who believed that the pleasures people value are not universal and that different groups within a society will value different sets of pleasures, such as aesthetics.

In relation to research then the outcome elements of utilitarianism can be applied so that the utilitarian researcher can argue that the ends justify the means. This would involve a reduction in the autonomy of the individual as participation in the study could be argued to benefit the population of lesbian mothers as whole.

³ Freud's pleasure principle is the principle whereby humans desire to act in ways that increase pleasure and avoid pain. This is a particularly immature response and as the person matures they tend to adopt the reality principle which enables the individual to set aside basic desires for pleasure when necessary.

The virtue ethics of skill (Kvale 1996) is a different approach, and possibly a more commonly used approach in research, whereby the internalised moral and ethical principles within the researcher are used reflexively to ensure that research participants are adequately protected. This means that the principles are less abstract and more contextual so that the approach is individual, sensitive and responsive within each situation. This approach may indeed be the one employed by most researchers because it acknowledges that abstract notions of ethics are not practical in real world research and are not necessarily flexible enough to deal with human participants who may come from differing ethical perspectives themselves.

However, in midwifery and nursing research the researcher should be mindful of the principles of care and an ethical stance that ensures the individual is not harmed by the research. The protection of patients and clients is paramount (Nursing & Midwifery Council 2004; NMC 2008) and these are the principles that should inform the research process in midwifery. Trust, autonomy and honesty are principles of midwifery care where the ultimate decision-making power lies with the individual woman and not with the professional. This standpoint is reflected in feminist research ethics which prioritise the individual and her (or his) context. These ethical principles have been described as 'values' (Edwards and Mauthner 2005) and emphasise the responsibility of the researcher rather than the outcomes of the research. This responsibility has its basis in the needs of the individual rather than the application of universal principles.

In this doctoral study the aim was to explore women's experiences of disclosure of sexual orientation or the decision not to come out to caregivers in their pregnancy. Those decisions, in the event, had to be explored retrospectively in all cases and there are issues to be considered in asking questions about the past. An important ethical issue in obtaining retrospective accounts of events is the risk of opening old wounds or leading a participant to view their experience in a different light than they did prior to the interview. This could be more positive or more negative. Clearly this is not the purpose of the research and the aim was to improve the quality of the experience of all women, regardless of individual characteristics, rather than to reduce the quality for the study participants.

Ethical approval was sought from and obtained by the University Research Ethics Committee. NHS Local Research Ethics Committee approval was not required, because the women were not being recruited by virtue of their status as NHS patients, nor were they being interviewed while accessing maternity care, regardless of provider (see Appendix I).

Management and storage of data, confidentiality and anonymity have all been acknowledged within the ethics process (Patton, 2002, and Silverman, 2005). With participants' consent, audio taping with a digital voice recorder was employed as this was essential for the purposes of verbatim transcription.

Interviews were downloaded onto a password protected university computer and could not be accessed by anyone other than me. The transcripts were stored in accordance with the Data Protection Act 1998 and were coded for identification purposes. I was able to cross-reference the code with the participant data but the transcripts were kept separately from the coding details at all times. All demographic or identifying data were stored on a university computer in password protected files. In accordance with the Data Protection principles, only data of relevance to the study can be recorded and no additional data, or data not deemed appropriate, is to be kept. The data was not used for any other purposes than those specifically related to the research study and will not be kept any longer than the period of the study. All data was anonymised and will be anonymised in any publications resulting from the research. All participants were informed that they had a continuing right to see any data relating to them and to have this amended if appropriate.

Obtaining consent

Purpose and challenges

It is generally accepted that consent will be obtained from all individuals who are approached to participate in research (Patton 2002). The basic purpose of asking for consent is to ensure that the participants agree to do whatever it is that the researcher needs them to do in order to gather the required data. This is not only a part of research but is a common sense concept understood in all aspects

of life. Obtaining consent has become part of everyday life in democratic societies where individual autonomy is protected legally, morally, ethically and constitutionally (Harris 1997). There are very few exceptions to this. However, the issue of consent is more contentious than it may at first appear.

Informed consent

In order for consent to be freely given ideally there must be no power relationship between the researcher and the researched but it can be argued that there is *always* such a power relationship. Power derives from being in a position of advantage, through knowledge, education, money or any number of other factors. And there is *always* a power differential between the researcher and the research participant (Miller and Bell 2002).

Simply asking someone if they are willing to participate in a study is clearly inadequate in terms of establishing that the individual appreciates the nature of the consent requested. This is where the concept of informed consent becomes relevant. Consent to participate in research is obtained in one moment in time. However, the very nature of human interaction and the impact of time mean that the circumstances of one moment vary from those of another. It is in this context that some argue for consent to be renegotiated as the research progresses (Sin 2005). For my part, consent was ongoing throughout the interviews by using phrases such as 'can I ask you about' or 'would it be all right

if we talked about' in an attempt to acknowledge that I did not see consent as a single event.

Consent was obtained from every woman who agreed in principle to participate in the study (see Appendix III). This type of consent involves the researcher providing the background of the study to each individual as well as responding to questions that might be asked prior to consent being given. Women could only fully consent to participate in the study if they had as much information as they required in making an appropriate judgement about participation. A participant information sheet (see Appendix II) was produced which outlined the aims of the research and the steps taken to address ethical implications of the study. The way that ongoing consent was obtained is outlined later.

The data collection process

In this section the actual data collection process will be described, including reference to the specific methodological issues, the steps undertaken and the strengths and the challenges of the interviewing process. The challenges are important as they help to illustrate some of the issues involved in attempting to undertake research that aims to meet the needs of the participants and make them equal partners in the data collection process. The impact of this will become clear when the challenges are discussed.

Using the method by Fleming et al. (2003) described in Chapter Four, a series of six unstructured interviews were undertaken with eight women; two interviews taking place with both mothers. Although each of the participants had long term partners, only two requested to be interviewed as couples. All but one of the women was a birth mother to the children. One participant, Daryl, was not a birth mother but her interview data was included as she offered great insights into the relevance of the experience of the partner. Not only this but her story formed an inextricable part of Bernadette's story and their dialogue turned out to require both dimensions. This fits with Gadamer's explanation of horizons as being everything that a person brings to their understanding of the phenomenon. Daryl's interaction within this is essential for making sense of Bernadette's story. It would also have been impossible to remove her parts of the interview as this would have made Bernadette's interview meaningless.

Unstructured interviews were chosen to create narrative texts for analysis (Fleming et al. 2003). These enabled the participants to establish their own priorities in relation to the question and this proved invaluable in identifying the breadth of issues. They also resulted in very rich data which was not limited by an interview schedule. This narrative approach is described as a conversation that involves both the participant and the researcher (Blaxter et al. 2001) which links closely with Fleming et al. (2003) and the concept of gaining understanding through dialogue. It is the conversation that produces the data rather than simply the responses to questions.

The interviews were undertaken between November 2007 and March 2008. All participants incidentally came from one Health Board region of Scotland and had all had their maternity care experiences in the same Health Board area. This is likely to be the result of the initial key informants coming from this particular Health Board area. This meant that their experiences were similar in terms of the structure of care they received. The implications of this are discussed in the limitations section. All women had used NHS provision and the only private element was non-NHS antenatal classes for one of the women. These similarities were coincidental as there were no inclusion or exclusion criteria that related specifically to type of maternity experience. Although previous research has indicated that lesbian women are more likely to seek the services of a private midwife this was not the case in this sample (Wilton and Kaufmann 2001). This could be for any number of reasons, two of these being most likely. Independent midwifery is very expensive and far less common in Scotland than in England and also the particular Health Board area in which all of the women received care is well organised for providing reproductive care to same sex couples, and indeed single lesbian mothers. This was a consistent and recurring topic within the interviews and one which will be explored in the data analysis chapter.

The Participants

The snowballing technique necessarily required initial key informants to be 'out' to some degree. They had to be known to key contacts who I was asking to identify potential participants. Early on I had made a deliberate decision not to access women through the NHS and maternity services because of the risk of accidentally breaching confidentiality in relation to sexual orientation – otherwise known as 'outing'. In addition to this, the study was not about current experiences of pregnancy and maternity care but a reflection on past experience.

The initial approach was made through specific contacts working with the LGBT community in Scotland. I also asked a colleague working in that particular part of Scotland who had indicated that she might know women who would be willing to participate. Through these contacts the first three participants, Helen, Jenna and Daryl were approached. After each interview the women were asked if they knew of anyone who might be interested in being interviewed. Each agreed to ask women they thought would be willing to take part. Jenna, an LGBT activist, sent out an email to a contacts list for lesbian mothers. Interested women were asked to make contact or provide contact details and then were sent a participant information sheet which detailed the purpose and focus of the study, the aims of the study and the method being used for data collection, including the use of tape recording equipment. All of the women who requested a participant information sheet went on to participate in the study.

Unfortunately, it soon became apparent that the snowball was becoming a circle rather than growing outwards. This initially became obvious when I was invited to participate in a multi-professional study day for LGBT families where I met Alison who offered to take part. However, she had already heard about the study through Jenna's email. In addition to this, it became increasingly clear that the women were sometimes referring to each other in their interviews which meant that the snowball ceased to grow. I took steps to widen the recruitment net but with very limited success. I have discussed this further in the limitations in Chapter Nine.

The participants had all disclosed their sexual orientation in their pregnancies despite there being no inclusion or exclusion criteria in relation to disclosure of sexual orientation in pregnancy. The study aim was to explore the experiences of women in choosing to disclose or otherwise. All of the participants knew women who had been through pregnancy and had not come out as lesbian but each stated a belief that these women would not participate in the study. As a result of this all of the participants were 'out' as lesbian in almost all aspects of their lives, the main implication of which is that only the perspective explored is that of the position of having disclosed.

The perspective of women who decided not to disclose their sexual orientation cannot be represented in this thesis. There is no doubt that recruiting women who had chosen not to disclose their sexual orientation would have offered an

interesting counter-balance to this, particularly because the participants within the study generally expressed their experiences in positive terms. However, there was no simple dichotomy of positive and negative and the complexity of this positive definition is discussed in Chapter Seven. This might provide some clues as to why women did not disclose and would not participate. Having said that, all of the participants had such varied experiences and identified or contextualised disclosure in such different ways that this in itself was of value.

A detailed description of the participants is given later in this chapter. The complex nature of the participants, their backgrounds, their relationships and family structures is important for any interpretation of the findings and forms part of the reporting of the first stage of data analysis process.

The interviews

The interview process represented a steep learning curve for me as my previous experience of interviewing involved the use of an interview schedule. Unstructured interviews can be challenging, with greater possibility of moving away from the topic under study and so involved close listening to the women and some clarification where necessary (Elliott 2005b). Previous interviews had been with single participants who were midwifery students. Difficulties were experienced but were very different from interviewing this group of participants, as will be seen in this section. As stated, the process involved a significant

amount of learning and adaptation but the skills learned in using unstructured interviews meant that later interviews involved different approaches and problem solving approaches.

As discussed earlier in this chapter, a methodologically appropriate but adjustable initial question had been decided in advance. Although the question was very broad it was designed to trigger the woman's own experiences and enable her to situate the issue of disclosure in a way that was individually relevant. The question remained unchanged throughout the data collection process. All the interviews took place in a venue chosen by the participant and all of the participants chose to be interviewed in their own homes. This was partly for convenience and privacy but also became a way of attempting to minimise disruption.

Helen's interview was the first and the one for which I felt the most prepared in advance. This, it emerged, was a facet of naiveté in relation to unstructured interviewing. While Helen was forthcoming and interested, the practicalities of interviewing with a small child being present in the room, and the consequent disruption, had not been anticipated. Although this might have been less disruptive with a more structured interview approach, it caused significant problems with the unstructured approach as it was much harder to maintain concentration. Picking up salient points and referring back to these throughout the interview was an important part of the unstructured interview dialogue but

this proved very difficult with the distraction of a young child. At times I stopped the tape recorder during pauses for dealing with the needs of Helen's daughter Eve but this caused additional stress in relation to the fear of forgetting to turn it back on. After this first interview the tape recorder was left on continually so that this fear was eliminated.

The greatest impact of the interruptions from Eve was the disruption of the dialogue aimed for in unstructured interviews. The interview in the method developed by Fleming et al. (2003) should be dialogical with the data emerging from the conversation but the tension created by the disturbance in this dialogue made it difficult to sustain. Patton (2002) describes this approach as conversational interviewing which relies on context and varies with each individual participant. The main advantage is its sensitivity and flexibility to the individual circumstances and emerging data but the approach relies on the skill of the interviewer to manage the dialogue (Patton 2002). This was an issue in this early interview. However, Helen was forthcoming, intelligent in her responses and provided rich interview data. She was also able to articulate her thoughts and apply them to her experience.

The presence of children proved a perennial challenge. Only one interview took place without a pre-school age child being present for the majority of the interview. In each case the discussion in relation to time and place of interview involved the issue of children but each participant felt that the best approach

was to have the interview in their own home so that children could be distracted. Indeed, attempting to conduct the interview in any other environment would have posed greater challenges with less flexibility. Each interview became a process of adaptation. Having decided not to press the pause button on the tape recorder during times of interruption it became significantly easier to keep track of the discussion which meant that the thread of the conversation could be more easily picked up.

Once each interview was completed, the digital recordings were downloaded onto a password-protected computer and then listened to in their entirety several times, in order to get a sense of their general meaning. The interviews were then transcribed verbatim. This was not done by a third party as I felt it was essential as a qualitative researcher to remain close to the data. One of the main challenges with transcribing the interviews was the disruption and additional noise from the children; however, using a good set of headphones did improve this. There remain a number of small gaps where words were impossible to hear but the overall meaning is clear.

Field notes were an important additional source of information. Notes were made following each interview and were also used to contextualise each transcript. Many of these related to the problems encountered within the interview in relation to noise but also included reference to the overall sense of the interview and the primary focus where this was clear.

Participant profiles

In this section, I have set out the complex profiles of the participants, both as a whole and as individuals. These are presented in a table at the end of the section.

Participant demographics would normally include that information relating to the background of the participants that provides a picture of the person as an individual. This would include a range of factors such as age, sex, marital status and employment. However, in this study the demographics, particularly in relation to marital status are more complex and also the status of the woman as either out as lesbian or closeted was also relevant. As a consequence, this section does not only relate to age or employment status. It is, by the very nature of the sample, broader in its outlook. A table of participant relationships has been included in the background section of the thesis.

Relationship status in this context is difficult to define and the organisation of the family is highly complex when looked at across the women. For this reason, when discussing the participant profiles, a range of aspects of the women's backgrounds have been included such as political activism, genetic relationship to the children and donor. This level of contextual background is important when analysing the interview transcripts as the contexts of the comments may help to

ascribe meaning that is relevant to the individual woman. For example, when Jenna talked about invisibility in relation to 'being queer' it had a different kind of significance for her than it might have if she had been less involved in activism. Taking the issue of demographics to a different level hopefully helps to increase the sensitivity in the analysis of data.

Participant backgrounds

All names within this document are pseudonyms in order to protect the identities of the women and the confidentiality of the information they gave me (NMC 2008). Maintaining this level of confidentiality and anonymity in this particular study has additional complexity. Owing to the small sample size, their very specific case histories and the fact that they all came from the same locality identification is more likely given too much detail. To avoid this and further protect confidentiality the Health Board area providing maternity services for the participants has not been identified.

The eight women were aged between 30 and 42 although Jenna's partner was considerably older. All were well educated and in stable, long term relationships. Jenna's partner, Jo, had adult children from a previous relationship although she was not the birth mother of those children. Jenna did make reference to Jo's children in the context of her experiences. Only Karoline and Karrie were both birth mothers. Of the eight participants, only Helen described herself as being unemployed. Helen was continuing to experience the ongoing effects of a brain

tumour some years earlier. Karrie described herself as a stay at home mum as distinct from being unemployed.

The nature of motherhood

This aspect of the sample of women was fairly complex and emotive. All of the women who were interviewed singly were sole birth mothers to the children. Helen, Anne and Alison all had each given birth to one child but had not ruled out further children. Jenna had two children and did not plan to have any more. For Helen and Anne the decision about who would be birth mother was based on their desire for children and their partners' attitudes to motherhood. Neither of their partners had wanted to go through pregnancy and the decision was fairly straightforward for them. For Alison and her partner Sue this was much harder as they both wanted to go through pregnancy. However, the decision for Alison to be the birth mother was described by her as 'getting her own way'. This seemed very important to her.

The couples I interviewed, however, were slightly more complicated. Karoline and Karrie were birth mothers to one child each and Bernadette and Daryl had two children for both of whom Bernadette was the birth mother. For Karoline and Karrie this had been reasonably straightforward and both had successfully inseminated using known-donor sperm. However, in the case of Bernadette and Daryl, Bernadette had not wanted to be the birth mother a second time having had a negative experience with her first baby. Daryl was desperate to have a

child herself and underwent fertility treatment for three years without success. At this point Bernadette agreed to become pregnant again. This was significant in terms of the interviews because Daryl was the primary contact and the person with whom I made all arrangements. It was not until I arrived for the interview that I realised that Daryl had not given birth to either of the two children. She did, however, contribute significant amounts of relevant data within the interview. For this and for the other reasons already discussed I have included her in the sample.

'Out' status

Although not part of the inclusion criteria, all of the participants indicated that they were 'out' at work, in their families and also in the community generally. Alison stated that she and her partner were not 'out' to the neighbours because she did not see the need to 'advertise it'. Helen was not 'out' to her grandmother but was not unduly concerned about this. The issue of being lesbian or of being 'out' was not particularly problematic for any of the women. Lesbian mothers who were not 'out' did not agree to participate in the study although a number of the participants could identify women who would fit in this group. This obviously made the data focused in a particular way. 'Coming out' was seen as either positive or essential and also repetitive. Alison was the only participant who stated that she would let people, for example her GP, presume she was heterosexual. She felt it was easier and not worth the effort to disabuse people of those assumptions.

Level of LGBT community involvement

This might seem like an irrelevant aspect of the women's background but it was important because it related to the way the women experienced aspects of their maternity care and the experience of becoming mothers. This will be much clearer in the findings section where the data provided by the women can be related to and contextualised within their background. In order to make sense of the interview data the individual background must provide a framework for interpretation.

Jenna described herself as an LGBT or queer activist and often referred to this when making points. Both Karoline and Karrie were active within the LGBT community and this was also the case in their countries of origin (New Zealand and USA). They were strongly influenced by the political and legal aspects of equality in relation to sexual orientation. This formed a backdrop for much of their interview and they were both very knowledgeable about the issues. They provided a useful perspective in relation to international differences.

The community involvement of the other women was less politically focused and was similar, in nature if not detail, to the kind of group involvement towards which most other pregnant women and new mothers would gravitate. These were, however, influenced by the nature of their family structures. Anne was a member of a sperm donor network and Alison had been the secretary of a well-

established lesbian mothers group which was now defunct. Bernadette and Daryl did not see themselves as activists or political and did not see having their children as being an assertion of their rights but they were active in school activities and had attended toddler groups and other social networks for parents. Helen was involved in equality groups both within the religious organisation to which she belonged as well as elsewhere but did not seem to identify this as activism.

Donor type, status and involvement

This was another complex aspect of the population demographic. For each couple it was obviously necessary for them to obtain sperm from a source external to the relationship. This was achieved in a variety of ways and with a range of different consequences. Although no sample is entirely homogeneous, this group of participants demonstrated wide variation in relation to the constitution of their families. The role of the sperm donor varied from being considered the baby's father to being viewed only as the anonymous donor and the meaning that each of the woman ascribed to the role of the donor was important in the interpretation of their interviews.

Helen

Helen had decided to access a fertility clinic and anonymously donated sperm after giving serious consideration to finding a known donor. She had, at one

point, tentatively approached a possible donor but this did not proceed. Her daughter Eve was conceived prior to the change in the law enabling all children conceived through donated sperm to find out the identity of the sperm donor. Helen was very upset that Eve would not have the right to find out anything about the father because, to her, identity and knowing where she fitted was important. Helen was, however, reassured by the fact that Eve bore a strong resemblance to the maternal side of the family and therefore had an identity to which she could relate. She can see where she comes from. There was no contact with the donor and no mention of the role of fathers or father figures in relation to Eve.

Jenna

Jenna's family set up was unique within the study in that each of her children had a father who was one half of a gay couple where both men had wanted to become fathers. The men were actively involved in the lives of the children and referred to as the children's 'Dads'. Jenna felt that it was very important for each of her children to know their father. She felt that they had the right to the same opportunities that she had in knowing her parentage. It was important to her to know her own genetics and therefore it was important for her children. She did, however, talk about the way that the children having fathers contributed to her invisibility as a lesbian mother.

Alison

Alison used sperm from an unknown donor through formal fertility services. Like Helen, this took place prior to the change in anonymity laws and so her son Ben had no right to find out the identity of his 'father'. She and her partner had initially hoped to use a known donor but the friend they had intended to ask had been approached by another woman for the same reason and had declined although the reason for this was not clear. They also knew of women who had used known donor sperm and then encountered problems with the fathers in relation to custody and so they chose anonymous donor sperm. Alison had also thoroughly investigated the psychological effects of having no father and was reassured that male role models in Ben's life would provide him with sufficient balance in relation to this. Her decision to use an anonymous donor also affected her decision not to have further children. Because Ben would not be able to find out his paternal genetics she felt it would be unfair for a sibling to know who their father was, either as a known or unknown donor.

Anne

Anne conceived Stewart using anonymous donor sperm from the fertility clinic. Although she and her partner had considered a known donor they knew the problems that Bernadette and Daryl had experienced. Anne explicitly used this as an example. They had also asked several straight male friends but each had declined after discussing it with their partners. The final decision to use

anonymous sperm was related to their intention to migrate to New Zealand at one point. They knew that it would be much easier to do so without the need to obtain permission from a third party. They were given no choice in relation to hair colour or background of the donor but felt that Stewart was very strongly genetically linked to Anne and so this was not a problem. The decision for Anne to be the birth mother was straight forward as Diane had no desire to go through a pregnancy.

Karrie and Karoline

Karrie and Karoline were the only participants where each was a birth mother and where they had both used known donor sperm. Both women had used the sperm for home insemination and this meant that they had no contact with fertility or maternity services until the pregnancy was confirmed. They used a known donor because they wanted to know 'what they were getting' and also they felt that it would make it easier for the children to find out about their genetics at a later date if they chose to. Karrie stated that she had known adopted children and children with an unknown donor who had been very happy with their parents but wanted to know 'where they came from'. They hope to demystify this for the children. However, because Karrie was American, they had gone through a legal adoption in the US so that the fathers had no parental rights to either of the children. Neither woman referred to the donor as the father.

Bernadette and Daryl

Bernadette and Daryl were the only couple where a different type of donor was used for each of the children. They used a known donor for their first child although this proved to be highly stressful and resulted in an unpleasant legal battle for access. Because of their experiences with the known donor they used anonymous donor sperm from the fertility services for their second child. They did not express concerns about the differences in the known status of each child's parentage. What was important for them was the security of their family and their desire to avoid a repeat of the legal action.

The various family relationships and sperm donor status are represented in Table 1.

Table 1: Table of family relationships

Name	Partner	Birth mother to	Type of donor	Relationship of child with donor
Helen	Jules	Eve	Unknown donor (AID)	None *
Jenna	Jo	Ellie	Known donor A (SID)	Father
		Ewan	Known donor B (SID)	Father
Anne	Diane	Stewart	Unknown donor (AID)	None *
Bernadette	Daryl	Jon	Known donor (SID)	None [†]
		Mhairi	Unknown donor (AID)	None *
Daryl	Bernadette	Social mother	Unsuccessful fertility treatment	
Karoline	Karrie	Erin	Known donor (SID)	None
Karrie	Karoline	Iona	Known donor (SID)	None
Alison	Sue	Ben	Unknown donor (AID)	None *

ID – Artificial Insemination with Donor sperm (using fertility services)

SID – Self-insemination by Donor with known donor.

* No legal entitlement to trace sperm donor as sperm donated before 1st April 2005

† As a result of custody battle

The data analysis process

Finally in this Chapter it is useful to discuss the data analysis process and how this links to the chosen methodology. The data analysis process followed the method described by Fleming et al. (2003) which is very similar to other forms of qualitative data analysis methods, and the first step of this was to gain understanding through dialogue with the text. This is a four stage process and has been described in Chapter Four.

Once listened to and transcribed, the interviews were summarised in order to describe the broad meaning through first impressions. These summaries were fairly short and aimed to illustrate an initial meaning; particularly in relation the issue of disclosure. These initial meanings are presented in Chapter Six.

The second stage of this process of gaining understanding was the sentence by sentence analysis of the data in order to identify meaning units and codes. These can be words, parts of sentences, paragraphs or any portion of data that has its own meaning. They varied considerably in size. This made the analysed data look very uneven but that is acceptable within the method. The essential element is meaning not consistency (Fleming et al. 2003).

The third stage was a much deeper analysis which involved an iterative process of moving between dialogues and referring back to the initial meanings. Each

new idea, or code, was referred back to the previous sections to enable a deep interrogation of dialogues. This was very time consuming but essential in terms of Gadamer's *hermeneutic circle*. The circle is potentially endless as the process is eternally iterative however a pragmatic approach can be taken in order to leave the circle at a particular point because there is no concept of saturation (Debesay et al. 2008). Again, the purpose of this study was not a lifetime philosophical observation of the phenomenon but the use of an adapted philosophical perspective to a practical research method in order to reach useable conclusions. The reflection of meaning backwards and forwards across the dialogues allowed the horizons to be identified, compared, and moved forward to create new horizons of meaning.

The final stage of this part of the dialogical analysis was the identification of illustrative passages. These were the paradigm cases that illustrate the espoused meaning. This was important from a perspective of authenticity because it enabled me to show how the themes and meanings had been derived from the data. This is to say that the data analysis was subjective but aimed to be transparent in the conclusions drawn.

Using data management software

This is one area of the study that I changed part way through the data analysis process. This decision was related to methodological rigour rather than personal preference. It was the opinion of my original supervisor that since data

management software existed and the resource within the department existed then I should use it when analysing my data. Interviews produce large quantities of qualitative data and this must be managed in some way (Barbour 2008). This can be achieved through the traditional use of paper and scissors or through software packages. Software packages do not analyse data but help the researcher to organise interview transcripts, codes and also to make comparisons across the data (Richards 2005). I initially decided that using N-Vivo™ to support data analysis in this study was appropriate as it was supported by the university and it did not preclude other methods of managing data. The decision to use software related to the important way that it helps to handle data. Therefore the initial decision to use this particular package was a pragmatic decision based on its availability.

As N-Vivo™ is a complex software package a two day course was undertaken in order to develop a basic knowledge of its use. At that time, my associate supervisor questioned its validity in terms of the methodology being employed and expressed concern in relation to its methodological applicability. Having said that, it is a data management tool designed to manage data from qualitative research and so I considered it reasonable to continue.

I imported the transcribed interview data and started using it for analysis. However, the data was at times presented in a way that was counter-intuitive, and I began to feel that it was unhelpful in terms of the method of data analysis I

was employing. I lost track of the hermeneutic circle and began looking at very discrete aspects of data. Eventually, I began increasingly to use more traditional paper methods of analysis as this often worked better in terms of seeing the parts in relation to the whole. It was also physically easier to compare the interviews on paper rather than on the screen. Holding on to the context and seeing the themes as they fitted with the whole of the interview and the whole of the data set was often more effective on paper or using the features of Word™, for example the 'find' feature. The iterative process of reflecting the meaning units back to the whole was impossible using a software package because of the way that it tended to break the transcripts into small pieces. Therefore, for the bulk of the data analysis stage I did not use N-Vivo™. During the later stages of analysis I moved to Windows 7 and used the 'post-it' note feature. This enabled categories of coding and annotations to be posted on the computer desktop and sorted thematically. These snippets of coded data were stored on the desktop and accessed constantly through this stage of the process.

Summary

In Chapters Four and Five I have discussed the methodological challenges and decisions that I have made throughout the doctoral process. I have also discussed all of the relevant elements of the research process in order to be explicit and transparent about each choice and decision made. This has provided an audit trail of the last five years and demonstrated how I have maintained

integrity across the process in terms of philosophical approach and research method.

In Chapter Six my pre-understandings and the initial understandings following data collection are presented. These offer a foundation upon which the complex and detailed iterative process of engagement with the dialogues took place.

Chapter Six: Pre-understandings and initial understanding

Introduction

In this Chapter I discuss both my pre-understandings (identified prior to data collection) and my initial understandings (the first stage of data analysis). My pre-understandings provided the conceptual context within which the data were analysed.

The researcher's perspective – the identification of pre-understandings

An important element of qualitative research is the impact of the researcher on the data and its meaning. This is described by Fleming et al. (2003) as the researcher's own individual *pre-understandings* and this is part of the researcher's *horizon* in hermeneutic phenomenology. Identifying these pre-understandings is essential because the fusion of horizons is an integral part of the methodology and method. Pre-understandings are the knowledge, presumptions and biases that the researcher has in relation to the phenomenon under scrutiny (Gadamer, 2004). The researcher comes to these through experiences, through dialogue and discussion with others, and also through personal belief systems.

Pre-understandings are made visible through talking to others. The researcher has pre-understandings prior to starting the study but also develops these through the review of the literature. By the time the qualitative researcher arrives at the point of data collection they have had the germ of an idea, developed this through initial engagement with the literature, the discussion with others, formed a research question on the basis of this reading and discussion, and further entrenched this view through a more thorough review of the literature. Literature reviews are often seen as a way of discovering what is known about a topic. However, what is actually produced is the researcher's *understanding* of what is known about a topic. There has been a degree of interpretation and analysis even before data has been collected. This might be one argument for not undertaking the literature review in advance but as long as pre-understandings are recognised and acknowledged in advance then this becomes part of the process of developing new understanding. It is not possible to use the researcher's horizon if this has not been made explicit.

Much has been written in the research literature about the process of *bracketing* in phenomenology, and the identification of pre-understandings is a similar process, but the meaning of bracketing has often been misapplied (Paley 1998). Bracketing is a philosophical process that is reduced to the nutshell of making explicit the researcher's preconceptions in relation to the topic under scrutiny, and sequestering these preconceptions thereby preventing them from 'infecting' data analysis. However, even if this were possible, hermeneutic phenomenology

requires these preconceptions to become part of the overall understanding of the phenomenon. This was achieved using reflexivity which enabled me to recognise my preconceptions, acknowledge these, make them explicit and then explore how the research and its data analysis impacted on these. The interaction of researcher, participants and interview data cause all players to be affected (Paley 1997).

In qualitative research including hermeneutic phenomenology reflexivity is employed as a way of acknowledging the impact of the research on the researcher and the researcher on the research. However, this is not without its problems and anything that involves a high degree of self-knowledge is likely to prove challenging to some. It is a complex process that involves a range of influences (Mauthner and Doucet 2003) and it is not always clear where the boundaries are.

In Fleming's et al. (2003) method, the Gadamerian process of identifying pre-understandings is described. This is part of the process of reflexivity and self-knowledge but also recognises that the pre-understandings imposed on the data come from a range of influences. These include the individual, the social and the traditional (Fleming et al. 2003). Reflection on the identified pre-understandings helps the researcher to see their influence. It also helps the researcher see beyond them past the theoretical horizon where their understanding currently ends. It is only by seeing beyond the horizon that the fusion of horizons

necessary for Gadamer's hermeneutic phenomenology can be realised (Fleming et al. 2003, and Gadamer, 2004).

Included within the concept of pre-understandings is the idea of assumptions. The pre-understandings of a phenomenon create the assumptions that lead into a study and the lens through which the data is analysed. Making these explicit helps demonstrate that there is transparency in the analysis process and also so that the emerging findings can be viewed in relation to these existing concepts.

My pre-understandings

My own pre-understandings have come from a variety of sources; not least the many years of exploring the subject of lesbian motherhood. They have also come from having a Liberal and a Quaker upbringing. However, my practice as a midwife working within a philosophy of women-centred care also influenced my understandings and my assumptions about the study from the outset. These personal pre-understandings and my analysis of the literature led me to a set of assumptions that were constantly challenged throughout the analysis of the data although at other times they were consistent with the data.

These pre-understandings can be organised under a number of headings: the quality of the experience; the nature of the family; reasons for disclosure; and willingness to participate. These are described briefly below and at this stage I do

not intend explaining in any great detail how my assumptions were challenged but will return to this at the end of the chapter.

The quality of the experience

One of my assumptions, through my interrogation of the literature (Wilton and Kaufmann 2001; Jackson 2003; Lee 2004) was that the women would have experienced negative responses to their disclosure of sexual orientation. I also assumed that they would have feared disclosure. This would be consistent with much of the literature in relation to non-heterosexual individuals' experiences of healthcare services (Salmon and Hall 1999; Taylor 1999; Wilton and Kaufmann 2001; Röndahl et al. 2006). This is an important pre-understanding because the women assumed I was looking for negative experiences although I did not direct my questions towards either a negative or positive perspective. This is discussed further in Chapter Seven.

The nature of the family

Before undertaking this study I had a sense that, where there were two mothers, there would be a difference in the quality of the relationship between the child and biological mother and the child and the social mother. It was only when I had interviewed couples that I could see the parental dyad as being broadly similar to the 'traditional' nuclear family with two parents. By this I do not mean that one

mother took on a father role (although the nature of motherhood varied within each family) but that both women were parents to the children despite the absence of a genetic link. The non-birth mother (social mother) was the mother just the same and the dynamics were often the same as any other mother and child.

Reasons for disclosure

Following my previous work in this area I presumed that if the women disclosed it would be for three main reasons: to make themselves visible; to make a 'political' or personal statement; or to ensure the inclusion of their partner. I suspected that there would be an element of challenge and defensiveness in this disclosure. I also presumed that women would have no choice but to disclose information relating to sexual orientation given the heteronormativity of pregnancy and maternity care. This last assumption was not challenged through the interviews or data analysis.

Willingness to participate

Before starting the recruitment stage of the study I aimed to obtain a sample that included women who had disclosed and those who did not. I saw the disclosure in pregnancy as being entirely separate from the participation in the study but this was clearly not the case. Women who had withheld detail about their sexual orientation declined to participate in the study and I can only

presume that their reluctance to disclose in other aspects of their life extended to participation in this study. This made me very aware, retrospectively, that the study could not explore the reasons women do not disclose sexual orientation.

Making these pre-understandings explicit was a valuable activity as it gave me a way to compare what I was finding with assumptions made not only by me but by midwives and by broader society.

Initial understandings

One of the first stages of analysis using hermeneutic phenomenology is to identify an initial or naïve understanding: a kind of first impression of the meaning of the dialogues (Fleming et al. 2003; Lindseth and Norberg 2004). In this chapter I have presented all of the initial understandings through the first stage of gaining understanding through dialogue with the participants (the interviews) and the text (following transcription). These were used as the reference point for the later stages of data analysis where the parts were referred back to the whole. The whole was either the whole interview or all the interview data, and meaning was refined in the latter process with reference to the findings presented below.

Although these findings are somewhat superficial and descriptive, this process was an essential part of the data analysis process for my chosen method and also

provided me with excellent initial insights. The findings are presented in the order in which the interviews were undertaken. An additional benefit of presenting these initial findings, in this way, is that they are organised by interview and not by theme. They represent each individual woman's perspective and so, when themes and concepts are developed in Chapter Seven, they can be seen in the context of each woman's experience. By the time that data analysis was complete, these initial understandings indeed seemed naïve and while some of the broad issues remained, the meaning ascribed to these changed dramatically by the end of the process.

Helen

During the interview and later on listening to the tape for the first time I felt there were key aspects that arose and these informed the detailed analytical stage although it was certainly the case that I did not recognise the relevance of some of the points Helen made until after I had conducted more interviews.

Much of what Helen discussed were general features of pregnancy. These included aspirations for the birth, attitudes towards health professionals, hopes for the baby, relationships – with her partner and her own mother in particular – and health issues. Helen talked about the length of her labour, type of birth, and the kind of labour decisions she might make should she have another baby. However, when I asked if Helen felt that health professionals were likely to be

homophobic Helen stated a firm and clear belief that if the health professional was unhappy about her sexual orientation then they were more likely to ignore it and keep quiet than to comment or provide a lower standard of care. Helen saw this as a reflection of her entitlement to good care.

A separate, but in some ways related, issue was the way that Helen distanced negativity from her sexual orientation. She expressed the belief that where negative experiences were encountered they were a feature of the individual health professional expressing negativity rather than being related to sexual orientation. This type of expression recurred across the interviews and a much fuller analysis is provided in Chapter Seven. At this point it was simply the first indicator that the participants addressed negativity in a particular way.

Helen discussed the ways in which 'lesbians did things differently'. She discussed the attitudes of lesbian friends to pregnancy and the different ways in which they 'came out'. She also spoke about the way that lesbian mothers talk about the methods employed to become pregnant. This was compared directly with heterosexual attitudes to sex and becoming pregnant. For lesbian couples pregnancy was not about sex and for heterosexuals sex was not about pregnancy. In addition to this Helen made a comparison between her partner's attitude to pregnancy and ability to empathise with that of male partners of heterosexual women. Helen suggested that her partner might have been more empathetic because she was not a man.

Helen also talked about identity. She talked about her own identity but also about her daughter Eve's identity with an unknown father. She expressed profound disappointment with the fact that Eve had no right to seek out her donor (she never used the word 'father') but was comforted in the knowledge that her own genes were very strong so Eve looked very much like Helen and her family. This echoed across the interviews and developed into a much more complex theme as the data analysis process progressed.

Jenna

Jenna was the only interviewee who described herself as a *queer activist* and as such I anticipated that much of her interview would be political in nature. However, most of Jenna's story related to her personal observations and experiences of being lesbian and being pregnant or being a mother, which was, after all, the broad opening question.

The primary reason for Jenna coming out to her midwives was to be upfront and honest with them so that they did not feel later that they had been misled. This was the first point she made and was something she returned to within the interview. She did not want them to make a mistake relating to her relationship with Jo because of the perceived ambiguity in Jo's name. Although Jenna felt that it was not necessarily the case that others would assume Jo to be a man, she acknowledged that the context of pregnancy made this assumption more likely.

She also felt that it was important that people felt in control of the information that they needed in order to do their jobs well and this included the midwives. By disclosing right at the beginning she was enabling the midwives to have this control over information. This germ of a notion became more and more apparent as the data analysis process continued and eventually became a well developed theme within the study.

Jenna made the point that coming out was not a single event and that she consciously made the effort to come out with every new professional she encountered. She did this, as she says, 'almost before I was asked'. She felt it was relevant partly because she opted for a home birth. The reason for the home birth was not her sexual orientation or relationship but the fact that she had problems with antenatal depression in both pregnancies. She also felt that her depression had represented a different set of priorities and was a kind of distraction for the midwives. She wondered if her sexual orientation would have been more of an issue otherwise.

Disclosure enabled Jenna to talk about her primary relationship without having to lie or to be selective in the truth. She would not have to adjust her language or talk about her partner as 'they' rather than 'she'. Jenna felt that in the absence of disclosure, much of what was discussed with other people (including the midwife) would contain partial truths and this would have become very hard to sustain.

In common with all of the participants, Jenna stated that she had experienced no problems explicitly related to her being a lesbian mother. She had expected it to be an issue and had been prepared to 'defend' her corner but in the event her sexual orientation had not led to the challenges she had anticipated. She identified negative aspects of the experience but felt that these were nothing to do with her sexual orientation. This was very similar to Helen's articulation of similar encounters. Jenna's approach seemed to be to normalise her family. It was very important that the normality of her life was recognised. Jenna saw it as her right, which indeed it was. By coming out right at the start of the professional relationship she felt that the issue of being a lesbian mother was never 'an issue' because it was always just there. It had never been hidden and so was not a big deal.

However, Jenna was not entirely comfortable about the way she might be viewed. She felt that there was a certain amount of vulnerability for lesbian mothers because of the views of those people who might have some power over her family. This would include health professionals but also social services. She knew that there were people who her family would come into contact with and who would be able to exert control over the family if they felt there were issues such as questions of child protection. Jenna felt that this was more of an issue for lesbian mothers than for heterosexual mothers. Following the interview I had felt certain that this would become an important issue for other participants.

However, although the issue of vulnerability and safety emerged as an important theme, it was far more complex than the power relationship between professionals and the women.

Jenna talked about her identity and also about invisibility. There were two aspects to this. The first was that as a queer woman she was seen as being 'not queer enough' although she saw herself as absolutely lesbian. She said that within LGB circles she did not look gay enough because her hair was not right or the clothes she wore did not look queer enough. She also felt that the way she had chosen to have her family was not right either. Jenna decision to use sperm from known donors and to include these fathers in her children's lives was one that was not universally accepted among LGB circles. However, these fathers were very much part of the family and part of the children's lives in that role. The genetics of identity as well as the development of gender and role formation proved to be important themes later in the study as identity was a key component in each of the interviews.

The second aspect of Jenna's invisibility was the problem of being visible as a lesbian mother. She felt very strongly that it was not possible to be pregnant or to be with children and to be seen as being lesbian. She was distressed by the impossibility of being visibly lesbian and a mother outside her own circle. However, interestingly, the issue of not looking 'lesbian enough' caused her further problems from the point of view of her own identity integrity because

she felt that she was being judged as 'a good lesbian mother'. Not only did she believe that she did not look gay but she had chosen to give her children fathers and so received approval from within the heterosexual parent community that she was not seeking. This caused her frustration and she felt that by choosing to have children she was unable to be viewed as she wanted.

Jenna was clear that she was not just like everyone else. She said that she was annoyed by the suggestion that all women should be treated the same and that lesbian mothers were the same as other pregnant women. She said *'I'm not like everyone else. I'm queer and that makes me different. My needs aren't the same'* but she did feel that she was treated as an individual. She felt that the midwives needed to know that she was lesbian because they needed to know that she might have different needs. They needed to be able to ask what those might be and Jenna needed to be able to tell them.

A final issue was that of language. Jenna felt that midwives' use of inclusive language was insufficient to acknowledge her sexual orientation. Although the use of the word 'partner' was common and has been proposed as a positive move towards recognition of non-standard families, Jenna was clear that when midwives used the word partner they meant male partners. She also felt that the response to being told that her partner was a woman and not a man was 'not a non reaction'. It was never overtly negative or positive but neither was it neutral or natural. She felt the quality of the response was different from a normal

response but that this was not necessarily negative. It was an example of being different. This resonates somewhat with Helen's belief that health professionals who did not approve of her would avoid the issue rather than address it.

Anne

Anne's focus of interest was in two places: fertility treatment and her son's school. All the participants had their own main focus so presumably this is what the question triggered as being relevant to them.

Anne's first response to the question was to relate the story of how she and her partner Diane decided to have a baby and then the process of referral for fertility treatment. Like Helen, Anne offered examples of negative experiences that she then distanced from her sexual orientation. Anne mentioned that she and her partner had to go for counselling and suggested that this was because they were a lesbian couple requesting fertility treatment. However, when asked to say how she felt about this counselling she said that all couples have it so she had not felt it related to her sexual orientation. She did however make the point that she was sure that the counselling would take a long time to ensure they would be good parents, whereas in the event it was only one session.

Anne talked about the importance of being 'out' in her pregnancy although she related this more to other parents and also to the local community. Anne's focus was rarely on the pregnancy itself. She focused almost entirely on the fertility

treatment and being a lesbian mother or her son having lesbian parents. There was a strong sense from the interview that Anne was clear about their suitability to become parents as well as their right to do so. She stated that everyone had just seen them '*as a normal couple having a baby*'. She said that she would have defended herself against any disapproval by reminding others that she had tried for three years before becoming pregnant. For her, this showed her commitment to being a parent which she felt could have been perceived as requiring more planning and foresight than for heterosexual couples.

There were elements of stress related to specific moments of coming out. An example of this is Anne's description of introducing herself and Diane as a couple at the antenatal class. She described this as '*whoosh! We've done it now!*' It seemed that Anne felt vulnerable in this situation because of the close knit nature of some of the antenatal classes but, in the event, this did not appear to be a problem.

When asked about decisions around place of birth Anne did not express anything that indicated fear around this. In common with almost all participants she had suffered pregnancy related health problems. This aspect did not seem to be of great relevance to her. She never anticipated there would be a problem and she felt that there never was. This was as a result of living in a small community for a number of years and also meeting other gay couples at the fertility clinic. The number of lesbian couples meant that the hospital was well prepared for them

and barely batted an eyelid. This was seen as very positive. Familiarity with same-sex parents, and its role in the quality of the women's experiences became a much more fully developed theme following data analysis.

Discussing anonymous versus known sperm donation Anne said that she and her partner had discussed both but had decided against using a known donor because they wanted to be sure they could move abroad or make other significant decisions for their son without having to defer to another person. The nature of the relationship of the donor was an important element for all the women although for most the donor was not a part of the child's life. Anne had known a couple who had serious problems with a known donor. They wanted their son Stewart to be entirely their baby. This formed part of the complex theme of safety described in Chapter Seven and explored further in Chapter Eight.

Although initially joking, Anne also felt that the quality of care was affected by the presence of equality and diversity legislation and policies in the NHS. This was stated in a matter of fact way. The protection of the law and their right to be treated in the same way as everyone was clear for Anne. She also felt that she had been treated well partly because of the people who worked in the fertility clinic. She felt their care and attitude was genuine. She also put this down to the number of lesbian and gay people working in the NHS. She felt that it just was not an issue.

Anne was given a single room in the hospital and was unsure whether this was related to her relationship but suspected that it was related to her high blood pressure. This was important because Diane could come and go as she pleased. She talked about another couple who were not 'out' at all and how hard that must be. It was so important for her to have Diane around and also have her there as her partner. The role of disclosure as a tool for visibility and inclusion was present in a number of interviews, and was important at a number of levels.

Changing social attitudes towards LGBT people was recognised by Anne as being a factor in her experience of maternity care. She felt the changes had been significant over the past 20 years and that it was so much easier for her than it would have been two decades ago. The change in social attitudes was one of the aspects that made her feel more comfortable and less scared despite her own belief in her right to have a baby.

Anne finished with a story about the birth where she had been denied her own music by the Operating Department Practitioner. She had also found him very rough. Although Anne began by speculating that this was because she was a lesbian she also wondered whether or not it was just him. This event is revisited in Chapter Seven within the discussion of interpretation of negative experiences.

Bernadette and Daryl

The fourth interview took place with Daryl and Bernadette together, and this was a particularly interesting experience. As discussed in the previous chapter, all communication had been with Daryl and I therefore assumed she was the birth mother of at least one of the children. However, this transpired not to be the case. Even so, Daryl did the bulk of the talking and I felt this issue was very important to her. It was clear in this interview that Daryl felt very strongly about being included in the process as the mother of the children. Although she was not the biological mother, her involvement and inclusion was of paramount importance.

Bernadette started the interview by saying the experience was positive but Daryl responded immediately by identifying an incident which was clearly of great significance to her: the asking of Bernadette about her intentions for contraception. Despite Bernadette's repeated assertion that Daryl was her partner and therefore she did not need contraception, the midwife insisted on being given an answer so that she could tick the box. This disregard for the reality of the women's relationship was highly frustrating for both partners but particularly for Daryl.

The women experienced substantial improvements in their care between the births of their children which took place seven years apart. The women described

their first experience as 'awful' although Bernadette felt that this was more to do with resources and the organisational culture than their sexual orientation. Daryl felt strongly that they were not treated as a couple even though it was written in their notes that they were partners. The culture was also blamed and the fact that tensions were running high because of the imminent closure of the maternity unit. The role of organisational culture as a factor in the quality of care featured across a number of interviews. This was another important aspect of the discussion of negative experiences presented in Chapter Seven.

By the time the couple were having their second child they felt that the culture had changed significantly in that many more lesbian couples were having children. They knew a number of women who had been through the maternity services and also through fertility services. They felt that this increased exposure to lesbian couples having babies had helped improve the overall experience as the hospital was much more set up for them. They also felt this had taken only a few years for a real change in attitudes. Again, this concept of familiarity in relation to care for lesbian mothers was to prove important as themes emerged and developed.

The couple also talked about their own attitude to their relationship. They stated on a number of occasions that they were not out to make a statement or to cause a reaction in others. They felt they were laid back and relaxed about being a couple and so others were also relaxed about it. Their approach was to be non-

threatening. They did not consider themselves to be activists and they expressed a belief that this helped to keep others on side. Bernadette wanted them to be seen as a normal couple and to be treated as such. This was partly influenced by media coverage of same sex couples having children and this very negative publicity clearly made them nervous.

Bernadette felt that by the time she was pregnant with their daughter Mhairi she was much more confident and felt she would have been able to stand up for herself more although the reality was that this was unnecessary. Daryl also felt strongly about this. She would have insisted on being included if she had to as she had come to believe she had a right to be treated this way. Entitlement, again, was a strong recurring theme in the interviews.

The experiences of pregnancy related by Bernadette were so traumatic that she would not have considered having further children if Daryl had been successful with fertility treatment. Unfortunately she was not but it was Daryl who was desperate for them to have another child. It was during this interview that I first realised what it meant that both women were mothers despite the genetics. This motherhood was very real for Daryl and became very obvious to me.

When talking about their experiences at the fertility clinic Bernadette felt they were treated well, perhaps because of the thought that had gone into them becoming parents. It was not a frivolous decision and therefore they were taken

more seriously or treated with more respect. Daryl also spoke of the closeness with the staff at the fertility clinic because treatment took place over a long period of time and had emotional highs and lows. She felt that there was a lot of reciprocated disclosure at the clinic and more of a relationship with the staff, despite them not being involved in the maternity aspect. There was more of a connection. Their positive experience with the fertility clinic influenced their feelings towards their birth experience with Mhairi.

There was also an important discussion here in relation to known and unknown sperm donors. Bernadette and Daryl had experienced serious problems with Jon's donor⁴ and so they chose the fertility clinic with Mhairi. This was an intense part of the interview and each couple have had their own experiences in relation to sperm donors. Bernadette felt vulnerable because Jon had a known donor. She felt there was a third person who could take him away but with Mhairi she felt the baby was all theirs and no one could ever have an interest in taking her away.

We talked about the assumptions that midwives make on the basis of the information they ask for and the women both agreed that there are assumptions around heterosexuality although interestingly Daryl felt that it was only fair to acknowledge that most of the couples are heterosexual so the assumptions are

⁴ Bernadette and Daryl used a known donor with Jon and then experienced a period of conflict in court in relation to access and visiting rights. Although the donor eventually stopped making contact despite winning his attempt to assert visiting rights, this experience made Bernadette and Daryl reluctant to use a known sperm donor for their second child.

to be expected. However she did feel that the staff forgot to give her information that the other partners were entitled to, for example different visiting times. They also talked about attitudes of health professionals in general and how, if these had been negative or anti-gay parenting then this would have affected their ability to seek medical advice. It would have made them feel vulnerable to social services.

They felt that it was important to be open with people in order to be fair. They related this specifically to the children's school but also to others. They felt it was unfair to expect good treatment and a positive attitude to them as a family if they did not disclose this information proactively. This, they felt, had worked well. They briefly discussed legal issues over guardianship and consent for treatment but this only related to the immunisations.

There was a brief discussion about inappropriate questioning by health professionals but both Bernadette and Daryl felt this was only genuine curiosity. People did ask questions but nothing inappropriate and always in a way that felt like genuine interest rather than intrusion. They were very relaxed about this aspect. The children's friends, for example, were described as considering it very 'cool' to have two mothers, however they did comment that for some people the acceptance of the same sex relationship did not stretch to the having of children. For some people this led to a reduction in acceptance. However, the couple stated that they lived in that particularly location because Daryl had grown up

there, her family lived there and she felt known and accepted. There was an issue of feeling safe. Also, they wanted people to be open about their attitudes. They appreciated honesty and felt obligated to be honest with others.

Alison

The interview with Alison was interesting because she focused on the difficulty she had making the decision to become a mother and the very deeply held views she had on whether or not she had the right to have a baby. There was a strong sense of gratitude and of her son Ben being a 'gift' and something she was very lucky to have. In this respect she was different from the other women as no one else expressed doubt about their right to be mothers.

The impact on Ben of having two mothers and not coming from a traditional family was something she had obviously thought a great deal about and had attended counselling in order to make the decision. She also researched the psychological effects on children from same sex families and eventually came to the decision that her child would not suffer by having two mothers. She talked about the need for strong male role models and how she sought to provide these for Ben. She also talked about the role that the father of one of Ben's friends had taken in providing 'fatherly input' for Ben. This was interesting because it could have been seen as an expression of 'disapproval' by this particular father who

was taking Ben's wellbeing into his own hands but Alison spoke about it as something positive and important.

Alison spent some time discussing the reasons why she would not have any more children and the issue of fairness to Ben and any future sibling was an important feature. Throughout the interview Alison expressed a desire and indeed a need to 'do the right thing'. She desperately wanted to become a mother but not at all costs. It was almost as if she wanted to acknowledge the concerns of wider society and show that she had taken these on board. In many ways she presented as part of 'normative' society and as someone who was asking permission to bend the rules. The primary impression experienced from conducting, transcribing and reading this interview was Alison's vulnerability. She was very happy with her partner and they had been together for a number of years. She never questioned her right to be with another woman but she did seem to wonder if in doing this she had to sacrifice her right to have a family.

As with every other participant, Alison indicated that there had been unpleasant aspects of her maternity care experiences. The examples she gave were quite disturbing but she did not believe they were a consequence of her sexual orientation. She put these experiences down to the culture of the hospital and applied her own expertise as a trainer to identify the organisational culture as the key to the poorer aspects of her experience. She stated a belief that the staff

had made more of an effort to be inclusive because they knew she and Sue were partners. This is explored further in Chapter Seven.

Karoline and Karrie

This was the second of the two interviews that had taken place with the couple rather than an individual woman. This final interview was notable by its focus on the legal aspects of lesbian parenthood. The couple also aimed to focus on the aspects of the pregnancy that related specifically to disclosure. Early on they mentioned the issue of disclosure as a way to be open with their caregivers and not to wrong foot anyone. It was important to be upfront so that the midwife (or whoever was providing care) had the opportunity to provide appropriate care and respond in the right way. This was by now a familiar concept within the interviews and I recognised it from all of the other dialogues. The women also stated that they chose their GP surgery specifically because they knew it was 'gay friendly'. They felt protected by this and felt that safety in a broad sense was an important part of the disclosure process. They were not unique in this belief as it was mentioned by all of the study participants to some degree.

Karrie and Karoline also talked of the difference in the experiences of the midwives in the three and a half years between each child. They felt that their second experience was in some ways easier because the midwives were more

experienced in caring for lesbian women. The more familiar the professionals were the more comfortable the experience was for everyone.

For Karoline and Karrie it was important that they were treated appropriately and that their rights were acknowledged. They also saw it as part of their role to change things for the better. When they 'booked'⁵ with their first child Iona they asked for the word 'father' to be crossed out and changed to 'partner'. Not only that but they also made it clear that they thought it was inappropriate to use the word 'father' on the documentation. They felt that they challenged the midwives and the maternity services to make changes and improve the access to appropriate care.

They appreciated the honesty of their midwife when she first provided care for them as she had no experience with lesbian mothers. She asked them to be patient with her and to correct her if she did things wrong and they felt that this was a genuine attempt to meet their needs and to learn from the experience.

The couple related a number of experiences which they had found amusing, if also frustrating. These included the sometimes inappropriate things that midwives said, for example the parenthood education midwife who looked at Karoline every time she used the word 'father'. In fact they felt that the parenthood classes represented the most heterosexism that they experienced

⁵ This is the common name for the first appointment following confirmation of pregnancy and indicating the starting point of maternity care.

and they again challenged the midwife to improve this. The couple felt that use of language was really important. They recognised the heterosexism of the language and felt that if this was changed then this would represent a significant step forward. Language was important for them. The effort to use language that could include all family structures was appreciated and seen as being essential in moving away from the heterosexism underpinning maternity care.

The couple described the birth plan as being important. They wrote their own which indicated exactly who the partner was and it was up to midwives to read it and deal with it. There was no cause for discussion and it is clear that they believed strongly in their rights to be a couple and to have children. They were upfront and also believed they could not be mistaken for sisters because they were different nationalities. Anything that made their relationship transparent was useful for them. It put the onus on others to ensure they were meeting the couple's needs.

The most interesting aspect in relation to this couple was the fact that the midwives kept making the mistake of assuming that when Karoline was pregnant with their second child, Erin, this was her second pregnancy even though it was clearly documented that this was a different partner and they were very obviously different people. Karoline said it was almost as if they had merged into the same person. She felt that her care was different and that the midwives were slower to identify deviations because they treated her as having given birth

before. They treated her as a parous woman rather than a primigravida and this appeared to have put her at risk somewhat. However, postnatally the midwives found it difficult because they did not want to presume she knew how to change a nappy but on the other hand did not want to offer her help unnecessarily. It was as if they were not quite sure how a lesbian partnership might work in relation to the roles of parents and the involvement of the other mother.

The ways the midwives understood the relationship and the family impacted in different ways. The midwives were unable to work out the relationship of Karrie to Iona when they came in to visit. Only the woman's own children were allowed to visit so they had to make sense of it by assuming that Karrie was bringing Karoline's older daughter in to see her and that Karrie was not related to Iona. The midwives could not internalise the fact of the children having two mothers.

A lot of the interview was taken up with the legal aspects of the relationship and the importance of disclosure in relation to this. Both women talked about the more qualitative or esoteric reasons for disclosure being balanced by the very serious reasons for example the nomination of the other woman as next of kin. They felt they had to make explicit the other partner's authority in relation to next of kin decisions that might have to be made. This was not something that heterosexual couples would have had to do. They cite the example of any man accompanying the pregnant woman to the labour ward being presumed to be the father even if he was entirely unknown to her whereas the lesbian partner is

invisible in terms of next of kin and her relationship to the baby. This was very important to them. They felt that their safety and the safety of the children were dependent on making the relationships and authorisation to make decision explicit.

The legal aspects led to emphatic and indignant responses by the women. They identified vulnerability within the law although they were very strong and self-reliant in their approach to the legal position. They were also proactive. However, they stated emphatically that no matter how clear they made their wishes and how explicit these were, in the eyes of the law they could be disregarded and this was patently unfair. They acknowledged that their wishes, particularly written wishes, would probably not be ignored but they knew that they could be and that this needed to change. They also used disclosure to send out a message to health care professionals that if they went against their wishes they would use anti-discrimination legislation to protect them.

When discussing the psychosocial aspects of disclosure they indicated that this was important not only for them but also for the children. It was important that their daughters would see the family being recognised as such. They also felt that Iona was beginning to notice when they were not being treated as a family. They felt that these more subjective aspects of recognition were important on a day to day basis but that the other, legal aspects were important because they could have devastating effects on the family.

They discussed difference and the ways in which lesbian parents might be different but they felt the important thing was to be acknowledged and recognised as a family. It was important to them that the midwife or GP or health visitor acknowledged the family and what the disclosure meant for them. The couple felt that they were treated differently by virtue of simple things like the paperwork having to be adapted for them. They did, however, feel that a neutral stance by health professionals was simply devolving or abrogating responsibility to treat them appropriately. For them, a neutral position did not demonstrate an understanding of the specific needs of the woman and her partner.

Summary

These initial understandings were important in the way that they both challenged and supported my own pre-understandings to some extent. I had stated a belief that the women's experiences would be negative, at least in part, and although they did relate incidents which could be viewed in that way, this was not the way they viewed their overall maternity care experiences. They generally experienced care as positive and where it was negative they found ways of explaining this. This was so clear, even at this early stage, that it warranted further exploration and the analysis is presented in Chapter Seven.

By the time the interviews were complete I had changed my understanding of the nature of motherhood as experienced in the families. Motherhood, and parenthood, in these families was complex and depended to some extent on the way the social mother defined her own role. It would not be true to say that all of the social mothers viewed parenthood with the same level of desire as the birth mother. Anne, Helen and Jenna's partners had no desire to go through pregnancy or to be the birth mother. They were very supportive of the decision to have children but would not have done so if the circumstances had been different. However, for Alison and Sue a decision had to be made about who would give birth, while for Bernadette and Daryl this decision was taken out of their hands. The lack of homogeneity across family structure was an issue that forced me to review my preconceptions of the lesbian family, naïve though that might sound.

Although I had a preconceived idea that disclosure of sexual orientation would have strong a political component this was only partially true. Even for Jenna, Karrie and Karoline, who were the most overtly political in their interviews, disclosure was used for more subtle and more layered purposes than political challenge. Listening to the interviews, transcribing them and reading the transcripts all confirmed that disclosure of sexual orientation was perceived as a right and as a powerful tool used to achieve a range of outcomes. These are all explored further in the next chapter and in Chapter Nine.

Finally, although largely an issue of recruitment, my belief that the women would want to participate and would trust me regardless of their disclosure status, was very quickly challenged. Whatever reason that women might have given me for not disclosing their sexual orientation clearly extended beyond their episode of maternity care. My belief, stemming from a general perception of increased social acceptance of sexual minorities, seemed suddenly naïve when faced with a failure to recruit women who had not disclosed sexual orientation.

In Chapter Seven the findings from the more detailed iterative data analysis are presented. The findings from the initial understandings are present as an echo but in-depth hermeneutic analysis enables a far more complex and sophisticated understanding to develop. These are discussed in full followed by a discussion of the interpretation of negative experiences outlined here in Chapter Six.

Chapter Seven: Main findings

Introduction

In the following chapter I set out and discuss the findings of the study under five main headings, or themes: being invisible and becoming visible; being upfront; being me and being us; being entitled; being safe/being careful. A further finding in relation to managing negativity will be presented at the end. These themes and findings are presented in a way that is consistent with the methodology by using verbs (*being invisible*) rather than phenomena (e.g. *invisibility*). This links the theme to the experience of the individuals rather than to something external (Lindseth and Norberg, 2004 and Charalambous et al. 2009). It is also consistent with Gadamer's own use of Heidegger's concept of *Dasein*; *being in the world* (Gadamer, 2004).

Each of the themes was derived from the individual narratives as well as the totality of the dialogues across each interview. The women might have expressed the themes slightly differently but were quite consistent in their understanding of disclosure of sexual orientation and their reasons for it. This meant that this stage of data analysis, or engaging with the dialogues, involved a great deal of consistency in terms of the findings. Analysing the parts and the whole worked quite effectively in this case. However, it should be remembered throughout the

findings section that none of the women withheld information about their sexual orientation during pregnancy and only one participant indicated that she did this at other times and in specific interactions, for example with her GP or her neighbours. This does mean that the findings only represent one aspect of the disclosure/concealment dyad.

Being Invisible and Becoming Visible

This theme is presented first because, as set out in my pre-understandings I had anticipated that invisibility would be a strong feature of the interviews. The subsequent analysis of the interviews demonstrated that, while present, this aspect of experience was far more complex than my understandings and the existing literature suggested. It is for that reason that there are two parts of the theme and these are presented together rather than separately.

Lack of visibility for LGB populations is a recurring theme within the literature in health and social care (Wilton and Kaufmann 2004, Fish 2009, Salmon and Hall 1999, and Taylor 1999). The absence of visible signifiers for sexual orientation (as opposed to other aspects of minority status) means that in particular contexts the presumption is of heterosexuality. This is particularly true in midwifery where the pregnancy is biologically heterosexual and, as discussed within the literature review, the maternity services are largely heteronormative in their practice (Röndahl et al. 2009). What the presumption of heterosexuality does is

to render lesbian motherhood invisible. It does this because the general population does not see pregnant women as being lesbian but also because, institutionally, maternity care is organised in a heteronormative way. Traditionally the paperwork used at the point of initial history-taking, or the booking visit, has perpetuated this presumption as has the history-taking aspect of the booking visit. This is improving, for example with the Scottish Women's Handheld Maternity Record discussed in Chapter Three, where women are asked the name and relationship of the person supporting them in their pregnancy. However, even where questions pertain to the partner it is arguable that there remains an underlying assumption that this partner will be male. The main example of this would be the question for parous women asking if this subsequent pregnancy is with the same partner. For a lesbian mother the question needs to be whether it is with the same biological father. Even the presence of a female partner cannot be seen as necessarily the catalyst for the connection. Many pregnant women bring a sister or female friend to support them antenatally and in their labour so this is also a presumption that endures. This means that maternity care is premised on this presumption of heterosexuality which puts the onus on the lesbian woman to make herself visible, if that is what she wants.

However, in this study *invisibility* did not emerge as being the most important factor in disclosing sexual orientation in pregnancy. That is not to say that visibility and invisibility were not present within the interviews. Tables 2(a) and

2(b) illustrate the relationship of the themes across the participants and also the comparative weakness of invisibility compared with the more positive focus on visibility through disclosure.

Table 2 (a) *Being invisible* thematic grid

	Self	Partner/ as a couple	Family
Helen		Discussed (personal focus)	Discussed (identity focus)
Jenna	Emphatic (personal focus)		Emphatic (legal and personal focus)
Anne		Discussed (not invisible – social context)	Discussed (not invisible – social context)
Bernadette/Daryl		Emphatic (role focus)	Discussed (school and social focus)
Alison	Discussed (used by participant for own purposes)	Discussed (role focus)	Discussed (school and social focus)
Karoline/Karrie		Emphatic (legal focus)	Emphatic (legal focus)

In Table 2(a) it can be seen that invisibility does exist as a theme within the interviews and is identified as a factor in the women's experiences of maternity care but the women do not view visibility in terms of its absence but in terms of finding ways to become visible. Table 2(b) clearly illustrates the role of disclosure in ensuring visibility and the way the women use it for this purpose.

Table 2(b) *Becoming visible* thematic grid

	Self	Partner/as a couple	Family
Helen	Emphatic (coming out as repetitive) Disclosure as essential for visibility in pregnancy	Discussed (social focus and visible but not recognised)	Emphatic (genetics focus – physical similarities to children)
Jenna	Emphatic (legal, social, personal, political focus) Disclosure as essential for visibility in pregnancy	Discussed (particular reference to names)	Emphatic (legal, social, genetic focus)
Anne	Disclosure as essential for visibility in pregnancy	Emphatic (social focus)	Emphatic (school, legal and social focus)
Bernadette /Daryl	Emphatic (Daryl as mother) Disclosure as essential for visibility in pregnancy	Emphatic (role as mothers and legal focus)	Emphatic (school, legal and social focus)
Alison	Discussed (managing visibility) Disclosure as essential for visibility in pregnancy	Discussed (legal focus and role as mothers)	Emphatic (social, psychological, genetic focus)
Karoline/ Karrie	Emphatic (personal, social and legal focus) Disclosure as essential for visibility in pregnancy	Emphatic (legal, social and role focus; role as mothers and next of kin)	Emphatic (legal, social, personal and genetic focus)

Disclosure was an important act designed to make sexual orientation explicit but was not generally described in terms of visibility or invisibility. All of the women made the issue of their sexual orientation and relationship with their partner visible very early on in the pregnancy and did so very explicitly to avoid the issue of assumptions. The participants in the study identified disclosure of sexual

orientation as being an essential part of having their status as a lesbian communicated. Without it there was no way to be seen as lesbian and for all of the participants, this was important.

However, only one participant used the language of invisibility and she did so in a very articulate way. Jenna was emphatic in stating her invisibility as a lesbian either when pregnant or with her children. Interestingly she was not saying that she was invisible as a lesbian mother but being pregnant or being a mother rendered her invisible as a lesbian:

*[Jenna] "...when you're pregnant and when you have kids you just disappear as a lesbian. I mean it's just...**nobody** would see you that way, **nobody** does, **nobody** wants to know about it and **nobody** would presume that, and it's really quite hard...especially because of the life I've lived before....and that's all I've done all the time to spending my time so completely invisible. I kind of welcomed the opportunity to be out...and it's...just...difficult...to have what is a big part of your life just vanish really easily..."*

Although disturbed by this issue of invisibility, Jenna felt that she was at least in control of this process of becoming visible when she was in a situation in which she could disclose. This did not mean that she would wait to be asked but would disclose in a context where this was relevant and possible. It would not, for

example, have been particularly practical to always disclose this when out in the park with her children. It is in the context of communication with others that the disclosure takes place; unless of course she had been with her partner where the disclosure could be achieved in other ways, for example holding hands.

Interestingly, Jenna also discussed what she described as *not being queer enough* either for heterosexual contexts or in her life as a LGBT activist. When I suggested that by being a mother she had found herself in a position where she was no longer visible as lesbian Jenna responded:

[Jenna] "Well I've always kind of been in that position because I've never looked kind of, I've never looked the part. I never have, even when I haven't got the kids kind of hanging off me. I never had the right kind of hair or the right kind of clothes. You know, it took quite a lot of effort to get people to realise I was working for an LGBT organisation fundamentally because that was me. And people quite often would think I was a straight friend of... So I got quite used to being not queer enough but I didn't realise this was going to be another thing that wasn't queer enough. It is quite... quite isolating."

Jenna almost perceived herself as failing to be visible, even within her own community as an activist within the LGBT community. Although pregnancy was an important trigger of invisibility, her failure to be visible as 'queer' within the

'queer' population was just as disconcerting for her and manifested itself as frustration. Visibility and invisibility was a wider issue for her and she had found herself being unwittingly 'approved of' by heterosexual society when all she wanted was to be recognised as being queer. She says:

[Jenna] "But also, it happens that one of the few things that I do do with other parents is the Rainbow Families thing which is with other queer parents so there actually I've kind of really hit on the problem of being an unusual queer family. It's quite unusual for lesbian parents by choice to have dads involved so we get lots of erm... 'Oh isn't it nice to be in a place where people just have two mums.' ... 'Isn't it nice for our kids to spend time with other kids who don't have dads' and I'm like 'well my kids do, actually.' And so in some ways that's, you know, that's an invisible identity so wherever we go we're not quite right."

The focus in relation to visibility was not only on feeling invisible but also a move beyond that to establishing ways of being visible in the community and in daily life through using techniques that promoted a kind of normalisation, either of the pregnancy or the relationship or, more often, the family itself.

Karoline and Karrie looked for other ways to make themselves visible as a couple and a family. In order to achieve this they gave each of the children both parents' names. This helped them remove the invisibility of the other mother by playing

on the assumption that if you are with the child and the child has your name then you are the child's mother. Karoline described it as using the assumption of motherhood in a way that would almost play the health professionals at their own game:

[Karoline] "And I guess what we're doing is playing on the way they make assumptions so we know there's no problems because we know that they make assumptions. So those assumptions are irrelevant if the children have both your names."

Karrie and Karoline used a number of other techniques to ensure their visibility as a same sex couple by amending documentation or inserting their own notes which were designed to spell out to health professionals everybody's place in the family. They made explicit references to next of kin and the right that each of the women had to make decisions in relation to the other partner or the children should the need arise. Interestingly, this attempt at visibility was misconstrued by one midwife as being a sign that Karoline thought she was going to die in labour.

[Karoline] "And so the second time around we also had a note saying that if there's any emergency care situation then Karrie is my next of kin and can make decisions on my behalf, and when our midwife saw that note she instantly took it as a sign that we thought the birth was going to be

terrible and that there was going to be an emergency which we didn't. We just know that sometimes and she started..."

[Karrie] *"And we had planned a home birth so we were really feeling quite ok".*

[Karoline] *"That's right and she saw this note on there and she said 'it's all going to be ok. It's not like you're going to die in childbirth. It's like no, no.' So we left the note but we moved it to the back so we didn't worry the midwives about what they were thinking we were thinking. But I think that it was kind of, sort of an extended disclosure in a way that we didn't do the first time around because we really aware of how important it was to nominate somebody in terms of some of those legal and medical decisions."*

Karrie and Karoline wanted to include as many explicit statements of their sexual orientation and their relationship to each other as they could so that there was no confusion about who the key players were, but they found their efforts disrupted by the misinterpretation of the midwife. This could be seen as something positive because the midwife was less concerned about them being a same sex couple than she was about the belief that Karoline's thought that she was going to die in labour. The use of written notes to make the fact of sexual orientation visible was an important technique for them, nonetheless.

Anne, on the other hand, talked about visibility and how this had been achieved through living in the same small town for a number of years. She and her partner had become part of the community through living and working there. When Anne became pregnant there was no issue because they were visible as a lesbian couple.

[Anne] "I know after Stewart was born it was important for me to go to 'under one' clubs, Happy Babes, playgroups and anything we could do to let people see we were a normal couple having a child... Because I think people just accept Diane and I for who we are and you know we've lived here in this house for 12 years and Diane's well known in the shop and everyone just knows us."

Anne did not see visibility as an issue and felt that she rarely had to disclose explicitly because she was known. The only place where she found that she had to disclose actively was within the antenatal class at the initial meeting. Anne and her partner Diane attended a mainstream NHS class and appeared to find this the most stressful encounter in terms of disclosing sexual orientation. She says:

[Anne] "I think for me that was almost the hardest bit because we had to go round and introduce ourselves and then introduce who was with us. And some of them had their husbands and one woman had her mother

and when it came to us I had to say well 'I'm Anne and this is Diane my partner' and I think that's just like 'whoosh, we've done it now' in that small enclosed...Because sometimes I think antenatal groups are ...none of us has ever kept together but I think that sometimes I think that it's terribly close."

It is difficult to draw conclusions about what Anne feared in relation to the last sentence although it could be she suspected that being visible as the only same sex couple in the group might somehow exclude them from an otherwise tight knit group. Or that perhaps this would cause the group to be less cohesive when she understood antenatal classes traditionally to be catalysts for the development of long term friendships.

The fact that Anne and Diane were known in their village worked for them in terms of accessing fertility services because Anne's GP already knew that she was in a same sex relationship and knew to refer her to the fertility services for artificial insemination. Once in the fertility system visibility was managed in a much more systematic way and this was true of all the women who used fertility services to acquire sperm. This early marker in relation to the sexual orientation of women acted as a form of continued disclosure within maternity services.

Daryl's invisibility as the non-biological mother of the children was important. Daryl felt strongly that she was made invisible by the system and organisation of

maternity care. To illustrate the point she discussed 'partner-only' visiting times in the hospital where she felt her role had not been acknowledged:

[Daryl] "I didn't know I could go anytime to visit you. Nobody ever said, nobody explained. Nobody treated us like a couple really."

[Bernadette] –"I think they thought you were my birthing partner and that was it. They didn't say 'oh, this is your partner' but it was in our notes actually."

The issue of visibility can be seen within all of the transcripts but is not necessarily identified by the women as being the primary reason for disclosure. Alison, for example, put an emphasis on visibility and invisibility only to the extent that it affected the family, and in particular her son Ben. While she was not embarrassed about her sexuality, there was a sense from the interview that for her it was a more private and personal issue. It became important when the family relationship was evident at a public level, for example nursery school. Often the women's reasons for disclosure were often far more pragmatic as can be seen from the next section.

Being upfront (being honest)

The issue of being upfront and being honest with others is probably the primary reason for disclosure identified by the women in all of the interviews. The idea of

taking the initiative in the relationship with professionals was explicit for all of the participants. They disclosed their sexual orientation to the midwife and other health professionals because they felt it was important to be open about it and not mislead them. Honesty and openness were seen as facilitating a trusting relationship and giving midwives the opportunity to provide good, appropriate care. The development of trust within the therapeutic relationship is important and it is generally seen to be the role of the health professional to promote trust through honesty, through absence of judgement, and through the provision of non-biased evidence-based information and care. The trust of the woman is encouraged and facilitated by the actions of the midwife.

The spread of discussion in relation to this theme is represented in Table 3 where it can be seen that the emphasis placed on this 'up front' approach diminishes slightly as the focus moves from the pregnancy to the wider social context. This suggests a link between pregnancy and a motivation to disclose but that hypothesis would have to be explored further in order to be tested.

Table 3 Being upfront (being honest) grid

	Pregnancy related	With health professionals	Wider community
Helen	Emphatic (disclosure as essential first step – access to fertility treatment)	Emphatic (disclosure as essential first step)	Complex, essential but strategic
Jenna	Emphatic (disclosure as essential first step)	Emphatic (disclosure as essential first step)	Emphatic (essential for social and legal purposes)
Anne	Emphatic (disclosure as essential first step – access to fertility treatment)	Emphatic (disclosure as essential first step)	Discussed (legal and school focus)
Bernadette/ Daryl	Emphatic (disclosure as essential first step – for fertility treatment)	Emphatic (disclosure as essential first step)	Emphatic (essential for social purposes)
Alison	Emphatic (disclosure as essential first step – for psychological purposes)	Essential (but disclosure used strategically)	Complex, essential but strategic
Karoline/ Karrie	Emphatic (disclosure as essential first step – for appropriate care and access to fertility treatment)	Emphatic (disclosure as essential first step)	Emphatic (legal and social focus)

A noticeable feature of the interviews was an early statement in relation to being upfront about sexual orientation and the woman's desire to take responsibility for that exchange. Jenna, for example, said:

[Jenna]“[...] I came out sort of at the first appointment with them when they do the bit next of kin so I put Jo's name on that and they said 'do you have a partner' and whatever. Can't remember how they phrased it but I

said yes and I did at that point make sure that they knew and I think in both cases I think they actually wrote female because she's called Jo and... [it's] a bit confusing... Well it isn't confusing really unless you're presuming really very hard that it's gonna be a man but I think people generally are.[...] I suppose the kind of main bit of it that every time I saw someone new I had to kind of make the effort to make sure that the subject came up which I tend to do anyway, which I tend to make sure people know before they make a mistake and because the issue of who you live with, who your partner is and who the kids' fathers are comes up, I guess, I did kind of make sure to put it up front... almost before I was asked about it...."

Jenna appeared to feel that she had a responsibility to others to ensure that they knew. She did not feel that it was her responsibility to try to make them comfortable with the disclosure but to make them comfortable with the fact that they had not be misled. Their responses to Jenna's disclosure were not an issue for her but giving others the benefit of the doubt certainly seems to have been a motivation here. Very interestingly, Jenna made a very strong statement in relation to giving a degree of control to the midwife or to other health professionals. She said:

[Jenna]"... I guess just that I kind of tried to not make it an issue by trying to make sure it was always there. So that I didn't get to the point of

anyone saying 'he' when I said 'my partner'...And I think it makes it awkward when you end up saying, no you're wrong and this is what the situation is. You know, I think if you put somebody in the wrong then they're more likely to be...to react to it badly so if you make sure they're, they always... I don't know. I suppose it's sort of like making people feel like they are in control of the information that they needed to have from the beginning then they're less likely to have a problem with it."

Jenna also acknowledged that if she had hidden the fact of her sexual orientation from others and they later found out then they might have felt less positive and supportive about it because they might have believed themselves to have been deliberately made to look foolish.

[Jenna] *"It did occur to me that I might have to be a bit more, do a bit more work about it and you know be a bit more defensive about it... but it never occurred to me that there was a possibility to not do it and it's always been my approach to put it up front so that I don't put people in a position where they feel they're being deceived. Because I think that that's when ... you can get problems with people who wouldn't normally feel that they had a problem with it. I think it's like they feel like you've put one over on them on purpose or made them look silly or made them look unprofessional by letting them make assumptions or something..."*

Bernadette and Daryl also acknowledged the importance of being open and upfront as a way of enabling others to become comfortable with the couple's relationship to each other. Daryl stated:

[Daryl] "And we don't make an issue about it, I think we're open about it but we don't make an issue about it...I think we're kind of, don't have a thing, don't make an issue we're just relaxed about it, sometimes it takes folk a bit of time to get used to it and other times people... are ok."

They felt that there was a chance they could be seen as trying to make an issue of their sexual orientation and antagonising others but this was something they wanted to avoid. They did not want to be categorised as 'stereotypical lesbian mothers'. Although this might seem like a judgement on my part, Daryl actually refers to this in relation to another lesbian couple they encountered at the clinic and she tries to distance herself and Bernadette from that perceived stereotype.

[Daryl] "I mean my maternity experience [Daryl is referring here to her experiences with the fertility clinic] in the [hospital] when Bernadette had had Jon there was a lesbian couple when I was there [inaudible phrase] but anything they did do was commented on and they were made out to be very different and they were making themselves out to be in some cases but they were kind of labelled as being the odd couple and I was

keen that we were just seen as a normal couple who just happened to be gay and were having children. We didn't want to make...an issue."

There is some link here with literature in relation to the attitudes of midwives and other health professionals towards women who are perceived as being demanding, and viewed as trouble-makers when they produce detailed birth plans or make specific requests that do not follow general patterns of care. It is not clear whether Daryl sees the other couple's behaviour as unnecessary and unreasonable or whether she did not want to be seen as being a trouble maker. What is clear, in what she says, is the fact that she wanted the family to be seen as a normal family. Being open and relaxed about their family setup was her way of ensuring this.

Karoline and Karrie also talk about being upfront and honest with the health professionals they encountered throughout pregnancy and beyond. Karoline describes how they wanted to avoid health professionals 'getting it wrong' in relation to their family structure and used disclosure consistently as a technique for avoiding this.

[Karoline] "But I think most of them we kind of disclosed very upfront to kind of put people on the right foot to lead so there weren't any misunderstandings so I think we got to be very very upfront and be really

clear about what our family structure is so that they have a chance to kind of...you know, have a chance to respond in the right way. Because otherwise they might not necessarily be a parent and I think that's often when people do sort of make little mess-ups really."

Interestingly, they, and others, use the disclosure to enable the midwives to do the right thing but there is no room for rejection or negative response. There is an assumption that this knowledge facilitates good care and this is an issue that will be discussed under the theme *Being entitled*.

Alison, however, anticipated that there might be issues with people to whom she disclosed, and while she was very sensitive to negativity she was very understanding of the fact that others might not be used to working with lesbian mothers and might not really know what to do or how to react. She expressed tolerance and understanding in relation to this although she still felt it necessary to disclose. In the context of the responses of health professionals and others Alison stated:

[Alison] *"All the health visitors and midwives after were all fine. A couple of them you know I can tell they're not that used to dealing with...haven't had many lesbian couples but you could tell they were really making an effort and they were being and that's fine. It took me long enough to get*

my head round it so I'm very open to the fact that some people find it's not part of their everyday experience..."

Alison here referred obliquely to her own concerns in relation to lesbian parenthood and her previously held fears about her son's wellbeing as the child of same sex parents. She seemed to reflect these doubts onto the responses that she had from those providing care during and after her pregnancy giving an impression that she was accommodating less positive or more challenging responses following disclosure although she dealt with outright negative responses differently, as discussed later in this chapter.

What is important in this theme is the use of disclosure as a way of empowering the midwife, similar to the way that midwives believe they empower women through knowledge. This will be discussed further in Chapter Eight in the discussion section.

Helen made a related comment about the way that she used disclosure as an almost strategically timed intervention when she felt that the individual to whom she was disclosing would be unable to display or express disapproval. Helen said:

[Helen] *"I think what... myself and my partner we kinda go with the thing where you sort of get to know people and you get into such a position where it would be really rude to have a problem with your sexuality kind*

of thing and that's how ...we do it ... but there are certain people you kind of gauge and you think, well you know, I don't think I'll bother ..."

Helen clearly made a decision at times not to disclose, not because of fear of response but because she had made a judgement that a particular individual probably would not be comfortable with the disclosure. This was usually a strategic decision designed to avoid what Helen described as an unimportant confrontation.

Again it is important to remember that all of the participants disclosed their sexual orientation to health professionals during pregnancy and they did so as a positive act and they took it for granted that they would disclose. They did not express doubt or conflict in relation to this disclosure except in relation to specific individuals or contexts. There is a sense that the women used their experience to make decisions about the limits of the disclosure, if indeed they limited it at all.

Being me and being us (being a couple and being a family)

In this section the issue of identity is addressed and is divided up into the identity of the woman, the couple and then the family. The three issues are too closely related to be completely separated from each other and the inter-relations are

important. However, in terms of the discussion here they have been organised under three subheadings.

The grid (Table 4) illustrates how the issue of identity spread across the three domains: the individual; the couple; and the family. Emphasis varied in these domains, with the weakest area as that of *being me*.

Table 4 *Being me and being us* thematic grid

	Being me	Being us (couple)	Being us (family)
Helen	Emphatic (disclosure as part of being myself)	Emphatic (social focus)	Emphatic (social and genetics focus)
Jenna	Emphatic (activism, queer status and identity focus)	Discussed (legal and social expectation focus)	Emphatic (genetic, social and legal focus)
Anne	Weak focus	Emphatic (social focus)	Emphatic (school and social focus)
Bernadette /Daryl	Weak focus	Emphatic (personal, social and legal focus)	Emphatic (personal, social and legal focus)
Alison	Emphatic (ambivalent – personal and social focus)	Emphatic (social focus)	Emphatic (social, legal, psychological and genetic focus)
Karoline/ Karrie	Emphatic (personal, political and legal focus)	Emphatic (personal, political and legal focus)	Emphatic (personal, political and legal focus)

Being me

The importance of lesbian identity was an area I discussed within my pre-understandings and one that I had anticipated would be more strongly or explicitly represented in the study. It was, in fact, an important and consistent

theme throughout the dialogues but was only referred to in those explicit terms by some of the women. Others made reference to issues that could be interpreted as being about self and identity. Only one of the women actually referred to the point at which she came out as lesbian to herself and the effect this had on her. For the others the issue or the event appeared very distant.

Alison, in her discussion around the issue of having children, referred back to her distress when she finally 'resigned herself' to being lesbian and how she immediately associated it with never having children.

[Alison] "...I remember when actually I eventually sort of came out. You know you kind of half come out and then it's actually when I eventually came out kind of to myself in a sense. And then I absolutely burst into tears thinking I really want to have children. And I remember talking to someone, an older sort of trusted person and they kind of said well you still can have children and but at that time, I mean that was in the... early 90s and I thought no, I couldn't."

When Alison said *"no, I couldn't"* she was making an explicit statement about how she felt about the inappropriateness of being lesbian and having children. Her reference to the 1990s placed her understanding at a time when it was much harder for lesbian women to access fertility treatment as there was no legal obligation to provide it. However, she still felt that she had to 'come out' in order

to be herself. She discussed the attempts she made to try to 'not be' lesbian because she felt it would have been easier to be have been heterosexual but in the end she had to be herself.

[Alison] "Sometimes I think it would be much easier to be straight. I do. I wish...I don't know that sounds a bit...Sometimes I do wish I was straight actually because it would have been a lot easier and if I was I would have probably had a lot more children by now and be living in the country you know, but I'm not. I tried going out with men for quite a long time but it was just... and you do try desperately hard [laughs] but you know so yep. But if I had married a man I would have been living...You know, it would have caused its own unhappiness."

Jenna, on the other hand, felt that disclosing her sexual orientation was always a way of being herself and being acknowledged as queer because that is who she is. When discussing her role within the LGBT community she uses a very telling phrase when she says *"You know, it took quite a lot of effort to get people to realise I was working for an LGBT organisation fundamentally because that was **me**."* Jenna expressed resentment at being assumed to be heterosexual.

Jenna also expressed frustration at being judged in relation to being 'a good lesbian'. This related not only to the way that the heterosexual community of other parents viewed her but also the gay community which was very important

to her but at the same time did not always recognise her, as was seen in the discussion on visibility. Much against her will, Jenna gained acceptability from the heterosexual community because both children had fathers.

[Jenna] "And sometimes actually I find I'm a bit uncomfortable with the fact that if I talk about the fact in mainstream groups and I talk about the fact that they have the dads and that's really important then I tend to kind of feel really 'approved of' like I'm a good lesbian mother because you know I don't hate men and they have dads [...] It seemed like an obvious thing for me. I do kind of dislike the feeling I sometimes get that I'm being more acceptable to straight society by doing that and I don't really like being acceptable to straight society and I don't really want to be acceptable to straight society if it's the kind of society that wants me to be acceptable you know?"

Disclosure of sexual orientation for Jenna was about being who she was but it also exposed her to the judgement of others and made her either a good lesbian mother or, in her view insufficiently 'queer'. It was clear that this situation was an unsatisfactory one for Jenna.

[Jenna] "But yes it does feel as if I'm being congratulated on not having gone the whole way to be really queer and I kind of think I have actually.

You know, I'm so queer that other queer people don't like me (laughs). I mean surely that gets you some points (laughs)."

Although Jenna disclosed proactively, taking the initiative in letting others know, she could not control the misreading by those to whom she disclosed.

Being a couple

Being seen as a couple was also an important aspect of identity although did not feature as prominently as I had anticipated. The importance of disclosure in order to be a couple seemed to have a number of purposes. For Anne, the importance of Diane being recognised as her partner related to the importance of having support in the pregnancy and the labour. The way that Anne described it would ring true for heterosexual couples as well. It was not a statement of anything more than the value she placed on having the support of her significant other during this period in her life. She described it by saying:

[Anne] "I suppose, I mean I know a couple, well they're not friends, and they're not out at all and that must be so hard. You know, whereas with me having Diane beside me and knowing she could sit and hold my hand or she could be with me in theatre as my partner and you know, I think that meant a lot to me that we could be out and it was fine."

Being able to behave as a couple, with simple gestures such as handholding, was very important to Anne as she found this to be a valuable level of closeness and support. Helen also referred to the importance of Jules being seen by the midwives as her partner because she needed Jules to act as an advocate for her in labour. In the event, it was her mother who marginalised Jules' role and attempted to take over but Helen wanted to feel that Jules could represent her needs at a time when Helen could not.

[Helen] "And she [Helen's mother] arrived and she was there after nearly 12 hours and wasn't able to accept that Jules was my partner and therefore had, you know, my wishes in her head and in her heart, she knew and my mum was like 'excuse me I didn't even know your birth plan. I didn't have a copy of your birth plan' so Jules was... talking about decisions about sort of like I'd made decisions about like you know caesarean section various things ... I did eventually deliver vaginally but it was touch and go there in the middle but my mum was questioning Jules' decisions and cos I was out of it, whatever, so exhausted and high on gas and air and just, you know, how you are...and just, I was just..."

Many of the references to partners related to very pragmatic issues such as support, decision making and consent. It was only Daryl who really expressed this in terms of the importance of the non-birth mother being seen as the partner and therefore the other mother of the baby. For Daryl, being recognised

as Bernadette's partner, and having the same rights as the other babies' fathers, was extremely important and very emotional for her. In a number of places throughout the interview Daryl referred to the fact that she was never told that, as Bernadette's partner and the baby's other parent, she was entitled to visit at any time, along with the fathers of the other babies. This was an important signal to her that she was not seen as being the same as the male partners. When discussing this issue in relation to the hospital, Bernadette and Daryl had the following exchange:

[Bernadette] *"But I think that was down to resources as well. I don't think that was just...I don't think it was attitude."*

[Daryl] *"But some of it was attitude. I didn't know I could go anytime to visit you. Nobody ever said, nobody explained. Nobody treated us like a couple really."*

[Bernadette] *"I think they thought you were my birthing partner and that was it. They didn't say 'oh, this is your partner' but it was in our notes actually."*

[Daryl] *"And they were uncomfortable about it so we were then more on edge as well."*

Even when Bernadette and Daryl were explicit about their relationship the midwives seemed unable to adapt their care to the context. When Bernadette

was asked about contraception it seems to have been impossible for the couple to clarify Bernadette's contraception needs.

[Daryl] "It's interesting what you said about disclosure because when I came to take Jon home the girl was trying to tell Bernie about contraception and Bernie was saying 'well this is my partner' and the midwife said 'yes, but what contraception are you going to use?' and Bernie said 'This is my partner' 'Yes but I have to tick the box, what contraception are you going to use?' 'But we're a couple' 'Yes but I need to tick a box.' 'Just put condoms down' and that's what she did. She ticked condoms."

It is difficult to imagine that the couple could have been clearer about their needs but the organisational pressure to tick a box, regardless of its relevance, seems to have been the over-riding factor in this clinical encounter. This does suggest a need for flexibility and adaptability in health care documentation although greater confidence on the part of the midwife would have helped. This echoes the findings of Hunter's (2004) work in relation to emotion work in midwifery practice. She found that midwives who worked in hospitals were more likely to exhibit a 'with institution' model of practice than community midwives whose practice was more 'with women'. The impact of the culture of the hospital and the perceived lack of flexibility and autonomy led to practice that was about meeting outcomes rather than improving quality.

The couple do, however, clarify that this incident took place when they had their first baby and that in the intervening seven years, attitudes had improved significantly. The importance of Daryl's response was clear. For the birth mothers, partner involvement was important as a source of support but for Daryl as a non-birth mother it was much more personal than that. Without the genetic link to the child, being recognised as the birth-mother's partner was the only way to be recognised as the baby's mother. An outward display of recognition such as having access to fathers' visiting times was important for her.

Alison made a similar point in relation to her partner, Sue. She explains how Sue had found it harder to be a mother because she was not the birth mother. It was not until Sue was made redundant and Alison went back to work that Sue began to build a stronger relationship with their son Ben. Alison believed that being recognised as a couple in the context of the pregnancy was more important for Sue, for the same reasons as Daryl. It required a much more explicit acknowledgement. To illustrate this point, Alison related the story of the antenatal classes and how disclosure enabled visibility.

[Alison] "... It was more important for Sue because of not having such an obvious role. And actually, [laughs] an absolute classic one...was when we went to ... the antenatal classes at the treatment centre [...] And ...the first couple of weeks Sue came along and there were quite a lot of men there

and it was all about how to change the baby and all the birth and all that. And then they said the next class is all about breastfeeding and they might have said that the men don't need to come along or whatever I can't remember but Sue cos she was really wanting to be part of it all she came along and she was the only partner that came and the woman who was taking the class thought she was there thought she was pregnant and she kept giving her a doll to try to practise and ... I didn't want to say in front of the whole class that she was my lesbian partner because there were no other partners there and I think I said Sue's just here to support me. And then think the midwife... thought I had a learning disability or something, I don't know what but some sort of thing that I needed a support worker or something along with me so... Sue was like both of us were just dying and I just hoping that the world would just swallow us up it was just really embarrassing and after that Sue just said I'm not going to anything else [laughs]."

This was another example of the midwife, or health professional, being unable to process the situation or the information being given. Sue wanted to be part of the pregnancy in the same way as any father would have been but this seems to have been made harder by the midwife's failure to recognise the relevance of Sue's presence. Admittedly, Alison was quite coy and nervous about the relationship and, reading between the lines, it appeared that no one in the group knew who Sue was, even from her attendance at previous classes.

Karoline and Karrie, however, always made their relationship very clear when at appointments and when they attended antenatal classes but the effect appears to have been simply to make the midwife nervous. They wanted the professionals that they met to moderate their language to move away from *father* and to using *partner*. They had limited success with this and it could be felt that the midwives felt under pressure which made them less able to function sensibly. Or it could be that the language of heterosexual pregnancy is so deeply ingrained it is very hard to moderate it in the short term.

[Karoline] “[...] our experience of the parentcraft classes were a bit strange but then the midwife who did those wasn’t our practice midwife. But ...when we’d talk about things, every time she said the word father somehow her eyes would land on me [laughs]. And I don’t know... and she did it a lot and I don’t know if she had done it on purpose but we did find that was a bit tedious and she did seem to be a bit slow about kind of...”

[Karrie] “My parentcraft class was incredibly heterosexist. That was where we came across the most heterosexism. Once they were just, even when we flagged it up and said ‘could you please work on changing your language here’ there was just none. And it could be just like once you say [frantic tone] ‘don’t eat the orange one, don’t eat the orange one’ they eat the orange one [laughs]. You know it’s that whole, convincing yourself

and ending up saying... 'say partner, say partner, say partner. Father!' [laughs]."

There was nothing sentimental about Karoline and Karrie's request to be acknowledged as a couple. They simply wanted the same recognition as all the other couples who access maternity services and they did not feel that this was an unreasonable request. It was a representation of the facts and although in retrospect they were amused by the midwife's failure to get this right, at the time they found it tiresome and unnecessary.

Being a family

Although being a couple was important, the issue that is much more prevalent in the interviews is that of the importance of being recognised and acknowledged as a *family*. The women wanted to be seen not only as a family but a normal family where the children in particular feel comfortable and happy. They wanted their children to see themselves as being part of a secure, normal environment where they would be develop into strong individuals with a well developed sense of self. In fact, identity seemed much more of an issue in relation to the children than it did for the women. I had anticipated that identity as lesbian would be an issue for the women; by far the stronger issue relating to identity was that of genetics and the children's sense of identity as they grew up. This influenced decisions around sperm donation although these decisions were complex.

When talking about disclosing family status to the nursery, Jenna says that disclosure was about enabling her children to behave in the same way as all the other children without discomfort being shown by the staff.

[Jenna] “[...] and I was quite, again, kind of careful about them knowing and saying ‘you will be happy?’ Because I want...them not only to not kind of not hate us but also to be happy with having her kind of draw pictures of us as a family and that kind of stuff.”

Alison did not want to be seen as different just because she was lesbian and in a same sex relationship. She was clear that she and Sue were what she described as, a normal couple. When talking about lesbian families and the variety inherent in them, Alison distanced herself somewhat and placed her family in line with other, non lesbian families.

[Alison] “It’s funny that I have been to a lesbian mothers group but I have more in common with some straight families because there is that assumption that just because you’re lesbian you’re going to be very similar to other gay people when actually you’re not.”

However, she did go on to say that it was good that Ben would have the opportunity to meet other children from same sex families. She saw this as a way

of normalising his family experiences because he would be able to recognise his family structure as existing elsewhere. She said:

[Alison] “. But it is a support to know other lesbian couples and it’ll be good for him when he gets older and he’ll see other people with two mums and whatever.”

No matter how strongly Alison felt about the normality of her family, she could not get away from the fact that they are at least in some sense different.

For Helen, Jenna and Alison the issues of genetics and identity were explicit and of obvious importance. Helen and Alison used unknown donors through the fertility clinic and both talked about the regret they had in relation to the lack of rights of their children to find out the donor’s identity. The law in relation to donor anonymity now enables children conceived from sperm donated after 1st April 2005 to find out their donor’s identity after the children have reached the age of 18 years. Unfortunately, both Alison and Helen’s children were conceived from sperm donated before this change in the law. Helen had believed that the legislation would be made retrospective but in the end that was not the case. Indeed it would have been impossible given the information provided by donors. Both mothers felt that their children had been disadvantaged and were disappointed on their behalf. Helen said:

[Helen] "...we felt a little bit let down that Eve ... would've had the right at 18 to go and check him out but she doesn't have that and that does upset me still ...but... we just sort of...I think we decided we just wanted to have a child who's gonna be strong and be loved and be so, so completely loved that she wouldn't feel, feel you know, that we'd done her wrong and she's a very strong little girl and she's very self-assured and knows exactly who she is and where she comes from"

Helen is, however, encouraged by her own strong genetics and the fact that Eve looks like her and other members of her family. For Alison, the fact that Ben cannot find out the identity of the donor has influenced her decisions around having more children. Although she would like more children she has more or less decided against this because she would feel that one child had an advantage over the other.

[Alison] "Yes. I have thought about more but decided against it because ...Well not completely decided against it because the male, the known male donor thing, if we had a known male donor I think that would be unfair on Ben because one child would have ...would have a known father and the other child wouldn't and I think that would be unfair. And the other thing, yeah because of the law change and the child has the option to find out at 18 I think that would be unfair as well because I just think

it's too unfair for one child to have that option that they might be able to find out who their biological father I think that's unfair."

Both Alison and Helen used love as a way to manage this perceived deficit in their child's identity. The supporting, loving family provided the sense and strength of identity. As discussed the last two chapters, Jenna, on the other hand, chose to use sperm from known donors who were a gay couple themselves. This means that the family had a structure of two mothers and two fathers. Jenna talked about how her own identity was important as a child and how fascinated she was by who she looked like. She expressed the belief that it is probably better, given the opportunity, to know both biological parents.

[Jenna] *"[...] it's because I think all things being equal it's probably better having contact with all your biological parents than not... And yes, and also when I was growing up I was quite fascinated about who I looked like and who my family were and I didn't think that if that was important to me then I could wantonly deny it to my kids if I could give that to them which I could so I did."*

Jenna acknowledged that this was probably not the way that she would be expected to feel, given that she saw herself as completely 'queer'. But the decision was not about her, it was about her children and their choices over knowing their genetic identity. Identity here is again very practical, relating more

to biology than psychology although interestingly the women did not discuss genetics in the context of a need to know, for example in the case of inherited illness. It was also an acknowledgement that the children might feel differently than they do and so should be given options.

Karoline and Karrie used sperm from known donors but then adopted the children under United States legislation⁶ thereby removing any legal ties with the donors. However, they consciously chose to use known donors so that the children would have options in relation to their genetic identity. They also felt comfortable with using known donors because they were used to the concept within their countries of origin.

[Karoline] “[...] I suppose we’d both come from countries where known donors had been the system for a lot longer than here and so it’s probably concepts that we felt a lot more comfortable about in terms of the future children’s choices.”

[Karrie] “And we saw a documentary where a woman who wasn’t a known donor was trying to find her donor, had been totally loved by her parents and they were her parents but still wanted to just find out who this other person was so just to remove the mystery around that...And we were lucky with that, we had some people to ask really...”

⁶ LGBT adoption laws in the US vary by State although often the position is that single parent adoption is permitted and same sex couple adoption is not explicitly prohibited. The key issue is whether second parent adoption is allowed in order for the social mother to adopt the biological children of her partner. This is allowed in many States and only explicitly prohibited in a small number e.g. Ohio and Nebraska. In a number of States the position is unclear and would have to be clarified in the courts.

There is recognition here that the children will have their own ideas about the definition of family. However, from the perspective of Karoline and Karrie they are clear that they are the sole holders of legal responsibility for their family and they worked hard to protect the integrity of that family. The decision about tracing genes for them lay with the children and not with the donor because they very deliberately removed any residual rights through the process of adoption, albeit with consent of the donors.

Being Entitled

The next theme to emerge from the interviews was important because it was used as a statement of power when discussing my research aim of exploring motivation for and systems which support disclosure. In the main, the women made reference to a range of individual reasons for disclosing and these have been discussed within this chapter. However, a concept to which each of them referred almost as an act of defiance was that of *being entitled* by which they meant feeling that they had a right (legal if necessary) to the same level of consideration as any other woman. (Similar issues will be discussed within the theme *being safe* but that theme relates more to strategies employed by the women rather than the presence of protective legislation). Within this theme it is clear that the women not only felt entitled to disclose their sexual orientation and the nature of their relationship with their partners but they also knew that

they were entitled to be treated appropriately by the staff. They referred to NHS equality and diversity policies and also legislation although not in detail. They referred to its presence rather than to the specifics. They did not encounter overt homophobia but they also did not actually expect to encounter it. They held strong beliefs that they would assert their rights in any situation of antagonism although none of the women ever took this course of action. There were several incidents where complaints could have been made in relation to care but these were not seen to have been related to the sexual orientation of the women and so did not require recourse to complaints within the context of equality and diversity. This in itself is interesting. The women seemed to suggest that they experienced episodes of poor care but it would only have been overt homophobia that would have led them to make a complaint.

Table 5 illustrates the emphasis placed on entitlement to disclose within a political and a legal context. Entitlement was seen as concrete, as in legally sanctioned, and philosophical in terms of equity and equality as positive organisational features.

Table 5 *Being entitled* thematic grid

	Legal	Political
Helen	Emphatic (NHS policy focus, legal and protected)	Emphatic (disclosure as a right, equality focus)
Jenna	Emphatic (NHS policy focus, legal and protected. System weaknesses.)	Emphatic (disclosure as activism, equality, identity and power focus)
Anne	Emphatic (NHS policy focus, legal and protected)	Emphatic (disclosure as a right, equality focus)
Bernadette/Daryl	Emphatic (NHS policy focus, legal and protected)	Emphatic (disclosure as a right, equality focus but averse to using disclosure for political statement)
Alison	Emphatic (NHS policy focus, legal and protected)	Discussed (averse to disclosure for political statement.)
Karoline/Karrie	Emphatic (NHS policy focus, legal and protected. System weaknesses.)	Emphatic (disclosure as a right, equality focus)

Helen, for example, was of the belief that accessing fertility and maternity services in a large city was a significant advantage in terms of awareness of rights. Helen believed that any midwife or any other person working within the health service who took issue with her sexual orientation would be more likely to avoid the issue than to challenge it directly.

[Elaine Lee] *“So they were more likely to ignore it than say anything particularly homophobic?”*

[Helen] “Oh yeah, yeah! Cos basically if we’d ever had anything overt, I mean the midwife who we swapped from the other one, and she said we were very welcome to put in a complaint and stuff like that and you know I think that people are very aware that people get really antsy about stuff and they do, they’ll say look we’ll put in a complaint if you’re homophobic [...] but it’s not happened in my pregnancy but I think, they know really that they’re in sort of like mainstream NHS and their inclusive, non-discriminatory policies gotta be adhered to, you know.”

As can be seen from this exchange, Helen was emphatic in her belief that she was protected and insistent that she would use that protection in the face of homophobic reaction. However, this was also an example of where the offer to complain was rejected because the poor behaviour of the midwife was not deemed by Helen to be homophobic. It might have been the fact that they were participating in the research which made them contextualise complaints in this way but presumably other, heterosexual, women experiencing episodes such as those described in the interviews would have complained on that basis; on the basis that it was poor care rather than looking for the motive behind it.

As discussed in the initial understandings, Anne stated that she felt her experiences had been the same as anyone else’s. When asked why she thought this might be the case she made her comment *“[laughs] Equality and diversity in the NHS? I dunno...”* Although she made this comment as a light hearted, throw-

away remark, she did go on later in the interview to suggest that anyone exhibiting homophobic attitudes would get little sympathy from NHS management. She herself worked in the NHS and felt that this was in fact a serious issue or at least an issue taken seriously by organisations like the NHS. This could be due to the rapidly evolving policy context surrounding the issue of diversity, with a focus on public organisations in particular.

Protective legislation for minority groups has been part of UK law since the 1970s where legislation prohibiting discrimination in relation to sex (Equal Pay Act 1970, Sex Discrimination Act 1975) and race (Race Relations Act 1976) were introduced. However, it was slow to move beyond race and sex and it is only within the last decade that similar legislation has been developed to encompass sexual orientation (Employment Equality (Sexual Orientation) Regulations (2003), Civil Partnership Act (2004) and Equality Act (2006)) and gender reassignment (Gender Recognition Act (2004)). All anti-discriminatory legislation has now been brought under the umbrella Equality Act (2010) which consolidates provision. Protection extends to goods and services and it is this legislation which protects lesbian women accessing maternity care. The increasing amount of activity in relation to legal protection both in the workplace and in the provision of goods and services has helped raise the profile of the equality and diversity agenda. The women in the study were all very aware of their rights even if they did not know the specifics of the legislation involved.

Bernadette very clearly illustrated this change in focus in terms of equality legislation and the increased awareness. She compared the way she was treated in her two pregnancies and believed that the improvement in her experience with her second pregnancy was at least in part due to the increasingly careful behaviour of health professionals. She discussed it in an exchange with Daryl:

[Daryl] "I think some people were uncomfortable with the situation and didn't quite know how to handle it. And they just stayed away..."

[Bernadette] "But everybody has their comfort zone and when you're out of your comfort zone you do tend to edge around whereas seven years later it's a completely different environment...more education I suppose and more equality now. People have got to be very careful in what they say to you and how they act towards you in the health profession. It's more than their jobs worth really [laughs]. It's a complaining society and they sue."

However, when asked if they would have complained in the circumstances of poor treatment with their second child Bernadette simply says that she would have offered constructive criticism to help other women avoid similar experiences. She expressed regret at not having done this after the birth of Jon but at the same time was happy not to have needed to do this after the birth of Mhairi. It was an indicator for her that 'things were changing'. Bernadette and Daryl were the only couple able to make an assessment in relation to change of

attitudes as they were the only ones with a child over the age of four and who had a significant time interval between their encounters with the maternity services.

Being safe/being careful

Through extensive engagement with the transcript data it was clear that protection and safety were key issues for the participants. This, however, was expressed differently across the interviews and the meaning of safety varied across the women. A number of issues emerged from the interviews which could all be seen as relating to safety but the way that this was expressed varied considerably. Categorising these issues has resulted in the development of four categories within this overarching theme of *being safe: clinical practice; legal vulnerability; protecting the children; health professionals as powerful*. These are represented in Table 6.

Table 6 *Being safe/being careful* thematic grid

	Safe practice (self and family)	Used for protection (family)	Legal vulnerability	Powerful professionals
Helen	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family)	Discussed	Discussed (avoidance)
Jenna	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family)	Emphatic (parental rights of donor; assumptions made by e.g. police)	Emphatic (child 'outcomes' reflection of family structure)
Anne	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family)	Discussed (social worker input)	Discussed (access to fertility treatment)
Bernadette /Daryl	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family)	Emphatic (parental rights of donor and next of kin status of social mother)	Discussed (school and social focus)
Alison	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family but also producing vulnerability)	Discussed (rights of consent by social mother – not emphasised)	Emphatic (child 'outcomes' reflection of family structure; access to fertility treatment)
Karoline/ Karrie	Emphatic (quality and relevance of care – efficacy focus)	Emphatic (disclosure required for protection of family)	Emphatic (parental rights of donor and next of kin status of social mother)	Emphatic (child 'outcomes' reflection of family structure)

Clinical practice

Embedded throughout this thesis is the concept that the quality of clinical care is an important feature of any woman's maternity care experiences. Midwives are bound by the Code (NMC 2008) and all other health professionals have their own standards by which practice is measured. Even without this the professional is bound by a duty of care to the woman. It is in this context that the women chose to disclose their sexual orientation so that the care they received would be appropriate in terms of their relationships. However, the women identified episodes where they felt that the relevance of their sexual orientation, or more specifically the nature of the pregnancy, was particularly relevant to the care.

Jenna talked about the genetic make-up of her children. Although she was birth mother to both of the children, each had a different genetic make-up by virtue of their different fathers. Jenna was aware that this could have clinical relevance in relation to her pregnancy but she did not know the specifics of this. She seems to suggest that she was under pressure to keep disclosing her sexual orientation because she was unsure in what circumstances it would be clinically relevant. Even although Jenna was an activist and certain of her rights, she did not want to seem overbearing or too forceful in relation to her disclosures so she felt uncomfortable with the extent to which she had to disclose.

[Jenna] "[...] I kept feeling like I had to keep telling people in case it's relevant that he's got a different biological father and ... I felt that maybe

I was being too upfront about it but I didn't really know when they'd be able to make assumptions, when, you know when they would feel comfortable making assumptions about the same family and the same genes. And so I...That felt a bit forced. I probably should have just said when is it relevant and when do I need to make sure that people know this but I didn't really..."

What Jenna wanted was to be told by her midwife the circumstances in which she was likely to need to disclose so that she would feel that the midwives had the information they needed, when they needed it. The fact that this information was also in the maternity notes does not seem to have made Jenna feel secure that the midwives understood the situation. Having said that, Jenna also felt that it is her responsibility to look for the occasions when disclosure might be necessary and to maintain a level of alertness that would not be necessary for women who did not have the issue of genetics. She took on this responsibility almost as if it was part of her role as a lesbian mother. It was a responsibility she had because she is outside the norm.

[Jenna] *"Yes...I suppose I thought of it as my job to be on the ball looking for all the assumptions they might be making. Which I suppose I probably wouldn't have been if I'd been in a typical mainstream situation with a male partner and even in a more mainstream situation where the second child has the same genetic relationship to the father..."*

The need for a specific acknowledgement by health professionals was echoed by Karoline and Karrie although in their case this acknowledgement was about the relationship and this will be discussed in the section *legal vulnerability*.

It is only possible to speculate about the consequences of disclosure in terms of the effect it might have had on the quality of care but there are clear examples where the women described episodes of care that seem well below the standard expected. For example, when Karoline was left to labour without progress for what she felt was an unreasonable length of time she put this down to the midwife not really recognising that she was not the same person who had given birth to their first child. Karoline talks about the constant disclosing that she had to do in relation to this being her first pregnancy:

[Karoline] *“Another time I had to do a lot of disclosing was when I was pregnant and people kept saying ‘oh is that your first baby?’ and you’d say, well in some cases it was important to say no it’s my second child but my first pregnancy[...]*”

It appeared to be important to Karoline that she did not say, ‘this is my first child’. She wanted both children to be acknowledged as hers but she also wanted the midwives to realise that this was her first pregnancy. It might have led to less confusion if she had taken the other option but for her this was not realistic.

What should have happened is that the midwives should have been able to practise safely with the information they were given. Karoline did admit to having felt vulnerable because of this confusion.

Legal vulnerability

This was an issue on which Karoline and Karrie focused almost exclusively. The absence of laws to protect them from issues around consent made the need for very clear and explicit disclosure essential. The couple were not in a civil partnership although it is not clear why this was the case, given their strength of feeling in relation to the legal protection afforded same sex couples. However, they used a number of techniques to ensure that they were protected.

One of the key issues for Karoline and Karrie was that of consent for treatment by one partner on behalf of the other. Consent for treatment for the children was also important. It was following Karrie's pregnancy that the women had decided to use written instructions as a way of ensuring that staff knew who was entitled to make decisions for whom. Karoline stated very clearly that the purpose of making this relationship explicit was to put the onus back on the professionals looking after them. It was seen as fair warning.

[Elaine Lee] "Did you feel more comfortable when you made it explicit, this issue of consent, I mean in your mind when you were faced with a

potentially problematic situation, did it make that more comfortable if you knew that they knew that Karrie was your next of kin?

[Karoline] *"Yes. Absolutely. And it also made me feel that if you mess with me I will... sue the pants off you, I will do anything I can, I have made it completely clear and it's in my rights that's it's clear and it's in my rights that I've clarified what Karrie can and cannot consent for and it sort of made me feel like if you mess with us then it would be something to take further because there's just no way this is ok. Because you're just, you're vulnerable really and you need to know that, that they'll respect that and it's always at the back of your mind that they **could** not, that they could possibly not but mostly they will respect it..."*

However, even in those circumstances Karrie acknowledged that the absence of legal protection left them to a degree at the mercy of the staff. While stating that she would have complained vociferously if she had been disregarded she admits that this would still be possible, despite a written statement setting out consent. She said:

[Karrie] *"[...]but I think also in our lives in different settings it hasn't mattered that things have been said and so it made me feel a little better but I also knew in the back of my mind that it would depend on who was there at the time. If something went disastrously wrong, if they would be phoning [abroad] to try to get Karoline's mother to give consent on*

something. So it did but it would be far, far better if there were legal arrangements around that..."

So disclosure was a way of managing legal vulnerability but was not necessarily effective in terms of its eradication.

The consenting to treatment for the children by the non-birth mother was a related issue. There was lack of consistency in relation to the way that the legal rights of the parents were interpreted, most commonly when it came to immunisations. When Karoline attempted to sign for immunisations for Iona (Karrie's biological child) the health visitor's protestations were met with an emphatic assertion of legal rights. However, when Bernadette and Daryl encountered the same situation with their first child they appeared less sure about the actual legal situation and they seem happier to accept it as merely procedural.

[Bernadette] *"The only thing that we did come against was the guardianship thing, you know when Jon was born, for his inoculations and everything. [The HV] was very apologetic but it had to be my signature and the first injection it had to be me who took him. And then after that I made you take him cos of the needles [laughs]"*.

[Daryl] “Just the first one and my name was on the records anyway as one of his parents so that was fine. But that’s the same for everyone. Well I don’t know about married couples but partners.”

Daryl made the assumption that this would be the same for heterosexual couples although she acknowledged that it might be different for married couples. She seemed happy to believe that the legal position would be the same with heterosexual couples but did not really have any concrete information on which to base that assumption. It was important that she did not feel excluded by virtue of her being the social mother. As long as the rules applied to the heterosexual population as well then the issue was less problematic.

Protecting the children

The issues under this heading are not legal issues of protection but encompass the various discussions around disclosure as a way of protecting their children from harm. Disclosure was used as a form of ‘testing the water’ in terms of the tolerance and attitudes of others. The more the children were exposed to outsiders at nurseries and schools, the more vulnerable they were seen to become and the women attempted to take steps to anticipate harm, thereby avoiding it. Almost by definition these discussions did not relate to maternity care but they were identified by the women as motivations for disclosure and they were a thread throughout the interviews.

Jenna discussed openness about family structure when she talked about her family moving in circles outside the immediate family and community. She wanted to know if the children are likely to experience problems so that she could remove them from the environment of danger. In the same way that she did with the midwifery staff, Jenna made the disclosure early so that there was no confusion.

[Jenna] "... just a couple of times I've been in a group and I've mentioned my partner is a she and a couple of people have sort of not really been as big a part of the conversation after that. I've never, you know it happened a couple of times kind of just about the point where they've just met me and I've made sure that they've known and it's not really gone any further and they've stayed at the other side of the group and that's been that. And I don't know whether my perception of that was an over reaction but I'm quite happy for them to just not to be coming in contact with the kids if that's how they're gonna react."

Towards the end of the interview I made a statement about the variety of family structures that the children would be likely to see at nursery to which Jenna perceptively responded that this is not generally the case when the children are young. Most of the families she encountered had a mother and a father, married or otherwise. She wondered if this might be the reason that she did not particularly circulate in the community of parents. Jenna stated that it is very

hard work protecting your children from the attitudes of others so avoidance was another way to cope.

[Jenna] "But for all people say there are all kinds of families and you'll meet all kinds of families well I don't or I'm quite aware that I don't...I don't know I don't think the reason why I've ended up not doing many mother and baby things is because of that...Kind of not wanting to make the effort because it always is a bit of an effort really to make sure people are ok and to keep the kids protected from people who aren't..."

Alison felt that she needed to protect her son Ben from her own ambivalence about bringing a child into a same sex family. She went to great lengths to be sure that having a baby as a lesbian would not have an adverse psychological effect on her son and that she was comfortable that she was doing the right thing. Interestingly she said that she had become more comfortable since he was born because he was a real person and not hypothetical. Her doubts had been a significant part of her life. She said that knowing that the midwives had cared for other lesbian mothers in her area was important. In the study by Wilton and Kaufmann (2001) the participants made the same point. Also, having contact with other lesbian mothers was helpful because Alison could trust that they would not disapprove but she recognised that she would have felt more vulnerable in a different part of the city or if she had lived rurally.

[Alison] *"I remember being very sensitive to what other people would think and I still am, I am quite sensitive to what other people think and it's something that I know that I have to... what's the word...in fact I spoke to someone, in fact I even went to see a counsellor before getting pregnant because I just I wanted to talk through all of those things and it was something that, you know, I was aware that I had to be very happy and clear about what we've done because I don't want Ben to feel, you know, that he's any sort of shame or you know, embarrassment or whatever so..."*

Anne used the technique of joining groups and trying to integrate into the community of parents within the town. She saw this as an important way of becoming, what she described as 'old news'. She also saw it as a way of being seen as an ordinary family. When asked if she had worries for Stewart in the future she responded:

[Anne] *"I suppose that's why I went to the under ones and I went to all these things so that people would see me with Stewart or Diane with Stewart or us together with Stewart and see that we're not any different from any other family hopefully."*

Anne also acknowledged that high school might be different but that many children have problems at high school. Her wish was simply that he did not experience bullying on the basis that he has two mothers.

Professionals as powerful

This final, short section includes a number of references that the participants made to the power that people in professional roles could have over the family. I anticipated more in relation to concerns about health professionals' attitudes in relation to suitability of lesbian women as parents. In reality, this was raised only briefly in some of the interviews but it was nevertheless interesting when it occurred.

Jenna talked about feeling under some pressure to be seen as a *“good example of a queer family”* which did happen as a consequence of the direct involvement of the two fathers. While frustrated by the need to prove themselves as providing a good family environment for children which heterosexual couples would not be asked to do, she found that having engagement by the fathers met this need. Although she and the family had not experienced any difficulties with people in official roles she saw same sex families as being vulnerable to problems. The following exchange occurred when Jenna was discussing her invisibility as a lesbian when she was with the children and their fathers.

[Jenna] "But it does mean that I guess you kinda have to be a good example of a queer family as well all the time if you look at it like that. You can't be failing. And it's quite hard to... be...failing and to have the risk that people are going to presume it's because of that..."

[Elaine Lee] "So do you feel there's more pressure as a family?"

[Jenna] "In the past because of experiences we'd had with Jo's kids I was...quite...nervous about the way that sort of people with official power over my kids would react to my family. But it didn't happen and I don't know if that's because they're... not problems in themselves, you know the kids don't have any issues."

The experience with Jenna's partner Jo's children was an incident with the police, a number of years ago, where the blame for the behaviour was put down to the family structure. Jenna stated that there had been no problems in relation to her children and professional concerns but qualified this with the fact that this might have to do with the fact that her own children had no problems – a fact to which she alluded twice. She did not speculate what would happen if there were problems with her children but it could be assumed that she suspected some blame would be apportioned to the family.

Alison discussed the power of the professional as being sufficient to stop her from having children at all. When she talked about her experiences of the fertility clinic she said that she kept waiting for them to say no, she could not have

treatment. Having taken years to come to terms with the possibility of being a mother she then convinced herself that it could not happen because someone would refuse to let it happen. She wanted desperately to have a child but felt powerless in the face of the decision makers. She said:

[Alison] “And I remember going up to see the [clinic]..., when we went for the initial consultation at the hospital I kept expecting them to say no the whole time. But it was actually, it was actually at the time they were actually treating quite a lot of lesbians. I didn’t realise, I thought it was only a few and it was actually quite standard for them to be treating lesbian couples but I kept thinking they were going to turn round and say, you know ... no. And we had to see a counsellor before and you know, I thought she was going to say no, and, you know, I think I was just, it was just such a...I just really, really wanted to have a child and I just thought that something was going to go wrong. But it didn’t.”

She expressed surprise that the clinic had so much experience treating lesbian women or couples and so much of her fear was based on her lack of contact with lesbian mothers before becoming one herself. Alison made a brief reference to having to see a counsellor prior to treatment although the purpose of this counselling was not made clear. However, Anne also referred to counselling prior to treatment. She had believed that they would undergo an extensive period of counselling to establish their fitness for parenthood but in fact the session was

only an hour. What is unclear from both women's accounts of counselling is whether it occurred for all people accessing fertility treatment or whether it was because of their sexual orientation. This lack of clarity is compounded by Anne's statement that they had counselling because they were a lesbian couple which was then qualified by the statement that this was for all couples. The following exchange between Anne and me demonstrated that Anne obviously anticipated that the role of the social worker would be key but then refocused this when asked how she felt.

[Elaine Lee] *"Counselling because it was an anonymous donor?"*

[Anne] *"No. Because we were a gay couple having children, how would our child be perceived in school or out in the community, how were we going to be perceived having a child and, you know, she made some scenario about her daughter coming in from school and asked 'so and so had 2 mummies, why do they have 2 mummies?' and she said 'What do you think I should have said?' so we just explained how we would explain it to other children and she seemed fine with that but that was weird because we really thought the counselling would probably be a lot longer as in several sessions making sure we were fit parents and all the rest of it but it wasn't at all[...]"*

[Elaine] *"How did you feel about having to have counselling?"*

[Anne] *"I presume anybody who goes through donor insemination probably has to have counselling, not just gay couples I think. So it didn't*

really bother us. I think we were thinking that we didn't see any reason why we wouldn't be proper and fit parents but, you know, you just hope social workers have an open mind all the rest..."

However, at the end of this exchange she hinted at the fact that the social worker who counselled them could have obstructed the process if she had been less open minded. In any event, the women felt that others could make decisions about them as parents and as families simply on the basis of their sexual orientation and that they had to behave in a more consciously appropriate way in order to reduce this threat. There is a sense that the women were negotiating the minefield of professional regulation and scrutiny and feeling approved of regardless of whether or not this approval was wanted.

Summary

In this first part of Chapter Seven I have presented the main findings of the study within five themes. These themes have been represented using the language of phenomenology in order to show how disclosure is not simply a responsive act by the woman but a highly personal, motivated process with purpose. The implications of this will be discussed more fully in the *Discussion* chapter and disclosure should be seen as part of the women and not separate from them. In this second part of the chapter I explore the issue of the management of negative experiences alluded to so far throughout the thesis.

A final finding of the study related to my expectation that the women would have had largely negative experiences of maternity care. This expectation was not borne out by the interviews and overall the women stated their experiences to be positive. However, this does not mean that negativity was absent from the experiences. Negative encounters and difficult episodes of care were experienced by all of the participants but the question arose as to the extent to which this related to their sexual orientation. An analysis of the interview sections where negativity was encountered revealed an interesting perspective. This perspective is less about what was said than it is about the way that the experiences were related by the women and the context in which they were situated. These findings are discussed next.

Interpretation of negative experiences

Introduction

In the interview transcripts, the emerging themes related to the particular reasons that the women disclosed their sexual orientation and how they felt about those disclosures. Interpretation of the dialogues was viewed through the lens of disclosure. However, given the loose structure of the interviews it was always likely that additional elements of interest would arise. Following both the superficial and in depth engagement with the written dialogues, one of the most evident elements of interest related to the women's expressions of negative, or

disappointing, experiences and how they tended to interpret or make sense of these. I have included within here an analysis of these representations of negative or challenging incidents as they were indicative of the way the participants defined their own experiences and they also resonate with health literature in relation to the way people manage 'difficult' health experiences.

Although the interview question that I asked was designed intentionally to be as neutral as possible, all of the women made a statement in relation to the overall quality of their experience. Each participant made an explicit statement early on that the experience was generally positive. This was of particular interest to me as I had not asked them about the nature of the experience. Indeed one participant was apologetic when telling me that she did not have any negative experiences to relate. She did, however, go on to relate one. This positive quality seemed to contradict much of the research relating to the experiences of gay populations coming out in a range of settings (Buchholz 2000; Wilton and Kaufmann 2001; Griffith and Hebl 2002) although given the changing social attitudes towards homosexuality in the UK, including legal protection and Civil Partnerships, this was not necessarily surprising. It should also be noted that the women generally related these events with good humour. There was no sense of obvious ongoing emotional trauma.

When the women described negative incidents they did so in the context of it being potentially related to their sexual orientation and possibly homophobic in

nature. They made speculative references to this possibility. However, even where the women did identify an incident as possibly being an expression of homophobia, they were quick to reinterpret, or rationalise this as something else. It is not possible to evaluate whether they did this for their own benefit or to convince me as an outsider but they seemed keen to frame their experiences in explicit statements of positivity. Most of the women ascribed the meaning of the incident to being related to the other person or to the organisational culture of the hospital where they gave birth. Given that all of the women were from the same health board area then the issue of culture could be valid although it would be beyond the data generated here to state anything more than a possibility. Aspects of homophobia were seen to be evident, particularly in relation to Alison's interview, but this homophobia was not seen to exist for the women. Although they knew it was there and they saw it, or had heard of it, for others, they did not see it in their own experiences or they did not admit to it as part of their experience.

In this section I give examples of these negative events while offering some discussion around the ways that each woman presented and interpreted these. As in Chapter Six, these are presented by participant to show how each of the women made sense of negativity in slightly different ways. This discussion draws on specific examples from each of the interviews where the women were managing their experiences of particular events. Some of the examples were referred to earlier in Chapter Seven but in this part are discussed as a kind of

discourse analysis where what is said is important to the extent that it tells the researcher something about the social structures and interactions that produce that discourse (McCloskey 2008). The number and types of events varied across individuals but each of the women attempted to 'manage' the experience, thereby remaining in control of it.

The 'negative' narrative episodes

Helen

Helen described the experience of her 13 week scan where she and her partner encountered a radiographer whom they found to be very rude and unpleasant.

[Helen] 'We didn't have a very good experience when we went for our first 13 week scan...She was a cow, she just really was...' (laughs)

Helen then goes on to explain the radiographer's attitude by saying *'I think she was like that with everyone. I think that's just how she was.'*

In expressing herself in this way Helen identified the negative event and then ascribed this to the personality of the radiographer herself. She distanced herself from the other woman's attitude, presumably because she recognised this as being possibly interpreted as relating to her sexual orientation. Indeed, there was nothing in the exchange to clearly indicate that the radiographer was

expressing any kind of personal attitude at all. However, Helen provides a clue that she thinks this could have been related to sexual orientation because she goes on to make a comment about inclusive policies.

[Helen] 'I think it was just...being in a major city, that makes a difference maybe...They know they've got to be more inclusive and if they've got a problem with it they'll just skirt around the issue...They'll just ignore it.'

So Helen identified the negative event, ascribed this to the professional and then made a further comment which brought it back to the context of possible homophobia. The fact that she suggests that health professionals will hide their attitudes was an early reference to equality and diversity legislation and its impact on treatment of LGBT individuals accessing services in the NHS. This formed part of the theme of *being entitled*.

Anne

Anne's story of the negative event was actually quite unpleasant although she was very good natured about it. She laughed as she related the story and appeared somewhat philosophical in relation to the events. Perhaps this was the result of reflecting on events of three years previously as she certainly expressed disappointment about the way it had affected her experience.

Anne said:

[Anne] 'When I went to theatre, all of the staff were female apart from the theatre technician...and we had the music we wanted Stewart born to and the CD was finished because it took so long...and he [the technician] was really rough...[Stewart] should have been born to mellow Icelandic music and he was born to Guns and Roses.'

The most striking point for me is that Anne seemed to be suggesting that this particular health professional might have been physically rough with her because Anne and Diane were a same sex couple. Although a somewhat obtuse reference to physical abuse it cannot be discounted because she tells this story in the context of the interview. Anne was aware that it could have been the personality of the technician but also that it could have been deliberate. She said:

[Anne] 'And that's the only time I've thought, is that because we're a lesbian couple or is that just him? But I can't answer that.'

She also went on to reiterate her point that he was the only man in the room. The fact that Anne says that she cannot be sure why the technician was unpleasant and difficult means that it is hard to assess the issues. Was this sexism or an issue of poor interpersonal skills? Or was it homophobia? The covert nature of homophobia and the increased professional awareness of the

equality agenda make this a potentially interesting debate. All of the participants made reference to equality and diversity legislation and the protection this affords. However, the potential that this legal protection has led to the 'hiding' of homophobic attitudes means that it works to protect against but not necessarily to change attitudes.

Bernadette and Daryl

In this interview, Daryl's contribution as the social mother was invaluable in providing a partner perspective. However, she did not only offer insights as a partner but her experiences and her understanding of these experiences form a significant part of Bernadette's own understanding in relation to the events. They form part of Bernadette's 'horizon' and the experiences of each partner are inextricable. The couple agreed that a great deal had changed between their two experiences of maternity care; however Daryl related negative experiences from the first pregnancy and both women disagreed about the reasons behind them. Daryl clearly felt that the attitudes were personal and related to them as a couple, while Bernadette saw it from a purely organisational perspective.

[Daryl]: 'it was a pretty awful experience really, for lots of different reasons.'

[Bernadette]: 'But I think that it was down to resources as well...I don't think it was attitude.'

***[Daryl]:** 'But some of it was attitude. I didn't know I could go anytime to visit you. Nobody ever said. Nobody explained. Nobody treated us like a couple really.'*

***[Bernadette]:** 'I think they thought you were my birthing partner and that was it.'*

Bernadette seemed unwilling to concede that the negative aspects of their experience were related to individual attitudes towards them. She was keen to view these in the context of a very challenging cultural environment and she was not alone in making that comment. The particular hospital where she gave birth was due to relocate and there was great tension among the staff. However, Daryl did not believe this was sufficient to explain the way they were treated. Indeed, the impact that organisational culture can have on care is an important one for all health care providers who almost necessarily see their clients at a time of vulnerability.

Bernadette went on to discuss a particularly poor aspect of care which could certainly be described as substandard care, regardless of the reasons behind it. Bernadette was a mental health nurse and she discussed the events following her emergency caesarean section (LUSCS). She described being left to 'get on with it', presumably because she was a nurse. However, the neglect evident here was particularly disturbing for me as a midwife and even Bernadette expressed

the thought that it could have been because of her sexual orientation. In the main, however, she was at a loss to explain it.

***[Bernadette]** “I felt I didn’t get any sort of aftercare. Whether it’s because of my sexual orientation or anything, I don’t know what it was all about but nobody came, nobody spoke to me, nobody looked at the stitches. I mean I had no idea what to do. I had a catheter in and I was just left to get on with it.”*

Daryl stated that Bernadette had been left to remove the catheter by herself. Daryl and Bernadette described a number of episodes of poor care but these all related to the first experience and were all discussed with humour and insight. Organisational factors were important here. The context was unit closures and centralising of services which Bernadette believed had led to significant stress. She was much more inclined to blame this than the attitudes of the staff towards lesbian couples. Again, the invisibility of the attitudes makes it very difficult to be sure. As Bernadette says, it just is not clear what the reasons might be. The increasingly speculative nature of the motives behind the outcomes was evident across all of the interviews.

Karrie and Karoline

Karrie and Karoline were the only couple where both partners had been birth mothers. They were both able to articulate the experience from both sides. One

of the interesting aspects of their story was the way that the midwives seemed unable to differentiate between the women and had a tendency to treat Karoline as parous although it was Karrie who had been Iona's birth mother. Karoline was clearly alarmed by this and felt that the staff were unable to deal with the couple appropriately.

[Karoline] 'I went over my medical notes with my midwife because I wasn't happy...and she was explaining 'well we don't really worry about the head being that loose if it's a second pregnancy...but if it's a first one then it's more of a concern.' I just wonder for a minute if they fogged out a bit on that one.'

When Karrie pointed out that Karoline was transferred after 24 hours of labour Karoline went on to express the suspicion that her labour was too long and that the approach to her care had almost been misinformed.

[Karoline] 'And I just wonder if it was a bit long? And that's just pure speculation. They just fogged it.'

While this does not appear to be a negative event as such, it is an example of potentially substandard care because the midwives and doctors did not seem to know how to respond. They did not know what it meant for Karoline to be giving birth to the couple's second child but for this to be her first pregnancy. The

question then arises as to whether they actually fully engaged with Karrie and Karoline as a lesbian couple or if they were unable to deliver care with that level of understanding. Although it is hard to imagine that the various professionals could *all* have forgotten how to provide appropriate care because they are confused by the circumstances, Karrie and Karoline see this as the only likely explanation. The implication of this for midwifery practice seems to me to be that women and their families will interpret their care in the context of their own understanding (or horizon) which can in turn lead to a reduction in trust in relation to the care provided.

Alison

Alison experienced a number of negative events in her pregnancy and these made me uncomfortable as a midwife listening to quite unpleasant episodes of care. Alison came across as quite vulnerable and I felt the reason for this was that she was the only participant who did not believe that she had the same right as any other woman to have a child. She was very unsure of the effects on her son. As noted earlier, Alison had felt, on coming out to herself, that she was forfeiting the right to have children and it had taken her a number of years to come to the point where she believed she could safely do this (safely as in not cause psychological harm to her child). She therefore appeared grateful for her baby and grateful for any care that she was given, from pre-conception and throughout the pregnancy. This is not to say that she was passive in her

experience but that she was very sensitive to the reactions of others and this enabled her to make astute observations about her pregnancy experience.

In the postnatal ward Alison acquired an infection which I could only conclude from the discussion was a perineal infection because she was unclear about this. This infection was not diagnosed in hospital despite Alison asking her midwife to examine her as she felt so unwell. When told that there probably was no infection Alison did not insist on being examined because she was so unhappy in the hospital environment. She felt the culture to be unhappy and bullying. There was great tension and stress and she wanted to go home despite being ill. It was not until the community midwife visited her at home that Alison asked for a swab to be taken and an infection was diagnosed.

[Alison] 'But actually, I should have been demanding that they take a proper look and take a swab and get antibiotics...And actually, when the midwife came out...[she said] 'but no you probably haven't' but I actually demanded that she take a swab and I did have an infection...But I've got straight friends and who've said exactly the same so it's not...She had a similar experience to me and she felt that it was a horrible environment for everyone.'

Alison also gave up breastfeeding because she was given no help and she wanted to leave the hospital so much that she changed to bottle feeding. The fact that

the midwives would not help with breastfeeding or examine Alison's perineum does open up the possibility that the midwives were unwilling to engage with intimate areas of Alison's body because of her sexual orientation. It is arguable that this was also the case for Bernadette when she was left to remove her own catheter and care for her own sutures. This is important as an indicator that sexual orientation is often viewed in terms of sexual acts. The person's sexual orientation becomes embodied in the act of care which then takes on associations that the care giver finds unacceptable even though they do not stem from the woman. Eliason (1996) found that healthcare providers so closely associated sexual orientation with sexual activity that they were uncomfortable providing care for fear of being approached sexually by the individual they were caring for. This does not seem to be an issue when caring for heterosexual individuals of the opposite sex.

The strong issues in relation to impact of culture on Alison's perception of the staff and the environment lends further weight to the argument that organisational issues have a direct impact on the quality of care that women receive.

Alison was the only participant who actually stated a belief that she had witnessed homophobia. However, she is clear that she was a witness and not a victim of this. She placed the reasons for this homophobia with what she describes as the 'bullying culture' of the hospital. She had been looked after in

the community by a midwifery student who she knew from (what she referred to as) the 'gay scene'. The student had been very open and when Alison expressed an initial intention to have a homebirth the student had been keen to attend. Alison encountered her again in the hospital and said:

[Alison] "When I went into hospital she was actually there on her placement and she just acted like she'd never met us before...And actually with hindsight I think that might have been more to do with her. Maybe in that environment she didn't want to out herself because I can't think of any other reason that she was [like that]...I don't know about the midwife scene. Maybe it's very straight...but the hospital certainly felt like a bullying culture."

This episode of 'fear' was all the more disturbing because it related not to a registered midwife but to a student. It set up an expectation of an exclusive rather than inclusive professional culture that runs entirely counter to the professional ethos. The principle of being 'with woman' and providing sensitive, individualised care in midwifery extends across the client spectrum. There are no exceptions within this philosophy of care and therefore the apparent rejection of sexual orientation in relation to individualism is a breach of this philosophy of inclusion. This is true regardless of the 'victim' being a student or a pregnant woman.

What all this might mean

Table 7 shows the ways in which the women indicated the possible relationship between the negative events and their sexual orientation both in overt and abstract ways.

Table 7 Individual interpretations of negativity

Participant	Event/ Person	Rationalisation	Reference to sexual orientation
Helen	Scan	Personality	Reference to NHS inclusive policies
Anne	ODP in theatre	Personality/ sexism	'Is that because we're a lesbian couple?'
Bernadette	Postnatal care	Organisational pressures	'Whether it's because of my sexual orientation or anything...'
	Visiting times	Resources	'Nobody treated us as a couple' (Daryl)
Karoline	Treated as parous	Speculation	'I just wonder if they fogged out a bit on that one...'
Alison	Postnatal care	Organisational culture	'But I've got straight friends who've said exactly the same so it's not...'
	Student midwife	Bullying culture	'I don't know about the midwife scene. Maybe it's very straight...'

There are a number of possible reasons for the way that the women interpret negative experience and distance themselves from these, and the main ones are discussed here. These are: maintaining the integrity of the birth experience through denial that the experiences were related to sexual orientation and a rationalisation (or accommodation) of these experiences; an honest belief that

the events were unrelated to sexual orientation; increasing invisibility of negative attitudes and a move from overt to covert homophobia.

The birth experience: quality and integrity

Since 1993 and *Changing Childbirth* (Department of Health 1993) there has been strong recognition at policy level that women and their families value the experience of pregnancy and birth. This has been supported in, and remains at the heart of, devolved government policy through the Framework for Maternity Services in Scotland (Scottish Executive Health Department 2001). The social importance of pregnancy and childbirth has been understood for much longer than that and there is a wealth of literature exploring the deeper and more personal aspects of this life event (Kitzinger 1978; Oakley 1979; Oakley 1980; Kent 2000; Kitzinger 2000; Gaskin 2002). These authors also seek to humanise care in pregnancy to protect women from the lasting effects of care that neglects the wider impact of birth.

In this context it is possible that the women were protecting themselves from negativity by distancing the reasons from the personal; that is, their sexual orientation. Maintaining the integrity of the birth experience in this way enabled the women to attribute the less desirable aspects to others.

The rationalisation of certain aspects of care has been shown to be used in other aspects of healthcare. This technique is used as a way of maintaining the

integrity of the individual and personal aspects of their identity. Although this rationalisation is presented in the literature as potentially something negative and occurs in negative contexts it is done in order to manage self-image. The management or maintenance of self-image through rationalisation, if successful, is a positive outcome.

Rationalisation as a protective mechanism has been shown to be a strategy used by patients to maintain dignity and personal identity (Baillie 2009 and Parizot et al. 2005). Baillie (2009) suggests that patients use both rationalisation and humour to maintain their dignity in hospital settings, with a definition of dignity that moves beyond the physical by including psychosocial factors such as self esteem, feeling comfortable and being in control. The use of rationalisation and humour is important here because they are steps that the individual patient can take for themselves rather than relying on nursing techniques to protect dignity. Baillie (2009) suggests that the nursing staff generally do not recognise patient attitudes as being relevant to maintaining dignity because they focus on the physical. This lack of understanding of the breadth of the concept of dignity means that it is left to the patients to take back control in its protection. By taking steps to manage their own dignity they are also taking back control.

Parizot et al. (2005) discuss the role of rationalisation in the maintenance of self image and identity in circumstances that challenge the individual's understanding of self. Where self esteem and personal identity come under

threat from external circumstances then rationalisation becomes a way of altering identity to accommodate the threat. The rationalisations also become a way of minimising the negative aspects of the situation and its impact on identity. Control by the woman is a fundamental tenet of midwifery care and is seen as something that women value. Using rationalisation here mirrors its use in more traditional patient settings where loss of control often results from the presence of illness and self care is less possible.

White and Johnson (2000) also discuss the importance of self concept and identity and how this is affected by interactions with health care services. Their discussion focuses on the rationalisation used to protect masculinity when health is threatened. In this case, rationalising the pain experienced by men during a heart attack distances the individual from the threat rather than facilitating adaptation. The refusal by the participants to see themselves as their illness is trying to present them means that they do not react to the symptoms they feel. Denial is also an important aspect of this process of protection. Rationalising the situation as being normal and denying the negative possibilities because of the threat to self concept protects the individual's identity but not their reality (White and Johnson 2000, and Miller 2005). In the current study it is possible to view the women's explanations and interpretations of the negative experiences that they narrated in these terms. But the importance of the experience of pregnancy and the transition to motherhood or family life and a very positive self concept and lesbian identity are threatened by the negative or inappropriate

responses of others. Rationalising these can be seen as an important strategy for self-protection.

Dissonance theory also offers a possible explanation for the women's responses. This theory postulates that people strive to maintain consistency within the individual's cognitive processes such as beliefs and attitudes (Starzyk et al. 2009) and when this consistency is disrupted, cognitive dissonance or discomfort is experienced. Dissonance is experienced as negative so individuals take steps to restore consistency by adjusting their beliefs, values and behaviours. The more important the elements of dissonance the harder the individual will work to restore equilibrium. However, they will do so by changing those elements which are most easily changed. In this case the dissonance experienced when the women's beliefs about their sexual orientation, their relationship with their partner and their much wanted pregnancy, were disrupted by the attitudes of midwives or other health care professionals, the dissonance could only be resolved by changing the meaning of the negative encounter. There was no other aspect to change.

Miller (2005) discusses the tension between lay and professional epidemiology and the way that lay people rationalise their behaviours or circumstances as a way to neutralise risk or impact. The need to distance the individual from the impact results from the absence of alternatives. Risk denial theory is generally associated with deviant behaviours (Becker 1963) but that is not what makes it

relevant here. Risk denial can be applied here because it stems from the lack of options open to the individual to change their situation or to be someone else. The women displayed a kind of lay epidemiology in their experiences of negative encounters but instead of the argument that illness happens to those who eat well and exercise, their argument was that negative experiences happen to straight women. This of course is true but seems to indicate a lack of willingness to engage with the possibility that it might relate to sexual orientation.

The absence of homophobia

Of course, it is entirely possible that the responses described by the women were not related to homophobia or otherwise to the women's sexual orientation. It has to be accepted that the reasons given by the women in relation to the experiences that they had could in fact be reasonable. There has been a significant shift in social attitudes to sexual orientation in the last decade within the UK and this has resulted in protective legislation both in equality and diversity, including the workplace and provision of goods and services (Equality Act 2010), and also in the personal sphere of relationships enabling civil partnerships and same sex adoption (Civil Partnership Act 2004; Adoption and Children (Scotland) Act 2007). The increasing visibility of the LGBT community in the UK and many other countries has led to positive change and an attitudinal improvement. There have been high profile appointments of openly gay clergy for example and this has helped to open up the debate about widening

definitions of inclusion. High profile celebrities who have disclosed minority sexual orientation have introduced an element of popular acceptability to an extent that was previously unknown.

The extent of this reduction in homophobia was recognised by the participants. Bernadette and Daryl almost exclusively described the experiences of the first pregnancy and when asked about their more recent experiences tended to dismiss these as having been fine. They were very clear that attitudes had changed markedly between the births of their son and their daughter.

It is also evident from the interviews that the fertility services in their particular Health Board area were used to supporting same sex couples either through donor insemination (DI) or the provision of advice in relation to self-insemination with known donor sperm. This willingness to support lesbian couples prior to changes in the law in relation to access to fertility services certainly indicates a more open attitude towards lesbian mothers. Although the experiences with this particular fertility service were not entirely without their problems, overall the women were well cared for and staff engaged with them at a good interpersonal level. They felt that staff engaged with them emotionally and were excited when a successful pregnancy resulted from treatment. There is a sense that the situation was somehow normalised through the process of intervention and fertility treatment. The women became clients accessing a service like any other client. They became known and were accepted. There is some evidence that

increased contact with lesbians and gay men has a positive effect on attitudes and it might well be that this was an outcome here (Anderssen 2002).

However, it would be naïve to conclude that homophobia no longer exists regardless of the improvements in attitudes towards the LGBT community and even if the women in this study did not experience homophobia there is ample evidence to show that it still exists, at individual, cultural and organisational levels, depending on the national context.

The invisibility of homophobia

The final issue raised here is the speculative nature of the negative experiences. The fact that the women were so consistently vague about the existence of negative attitudes and then the reasons for them meant that it was very unclear whether homophobia, or even just discomfort with the women's sexual orientation, was a reality. Previous research suggests that in the past homophobia was overt and very obvious (Wilton and Kaufmann 2001). Women experienced verbal abuse or inappropriate questioning which was very clearly and explicitly related to their sexual orientation. Care givers felt that they had a right to express strongly held views in relation to homosexuality and the right of lesbian women to have children.

The women in this study did not experience any overt homophobia and virtually no explicitly negative comments in relation to their sexual orientation. However,

it could not be said that they felt there was an absence of discomfort. There was an almost ever-present suspicion that all was not as inclusive and accepting as it seemed. As shown in Table 7 there was often a half reference to sexual orientation being the underlying cause. The reason given for this absence of overt criticism or negativity, for all participants, was the belief that they were protected by equality and diversity legislation. They felt that this equality agenda was so strong in the NHS and other public services that staff would not have dared to be overt.

This equality agenda was obviously important for the women who felt protected and felt they had recourse to support mechanisms if they experienced homophobia and it is clearly a more pleasant situation to be protected from prejudice and bigotry, but it does not in itself demonstrate a change in attitudes and the women were aware of this.

Conclusion

The hermeneutic phenomenology method used in this study was chosen for its unstructured approach that would remove or make explicit *a priori* assumptions. It enables a neutral stance and an open dialogue. In spite of a neutral question it seems clear that the participants assumed that I was interested in their negative experiences of maternity care. It is also clear that negative experiences do exist. The potential interpretations of the ways that the women managed these

encounters in order to protect their experiences of pregnancy have been discussed.

It is important to remember that this analysis relates to the way the women took control of the experience and did not rely on the midwife or other professional to meet their psychological needs. The women appeared to take back the initiative where disruption to their expectation occurred. From the point of view of clinical care by midwives this raises some issues. Effective communication and non-judgemental individualised care are basic elements of midwifery practice. However, from the discussion in this chapter, midwives do not always seem to recognise when they are not meeting this standard because they do not always recognise the individual needs. The fact that these episodes were accommodated through the actions of women means that they were not challenged as poor practice. Midwives already know that they must not display homophobic, racist or otherwise bigoted attitudes. What they might not realise is that when dealing with minority groups of women, their attitudes and behaviours will be viewed through a particular social lens.

In Chapter Eight, I provide a discussion of the findings across Chapters Six and Seven, identifying three theoretical concepts (the disclosure triad), three supportive mediators and the associated disclosure motivators, which are contextualised within the literature and lead to the conclusions and

recommendations from this doctoral study. These help to demonstrate how the findings relate to answering the research question and address the aims.

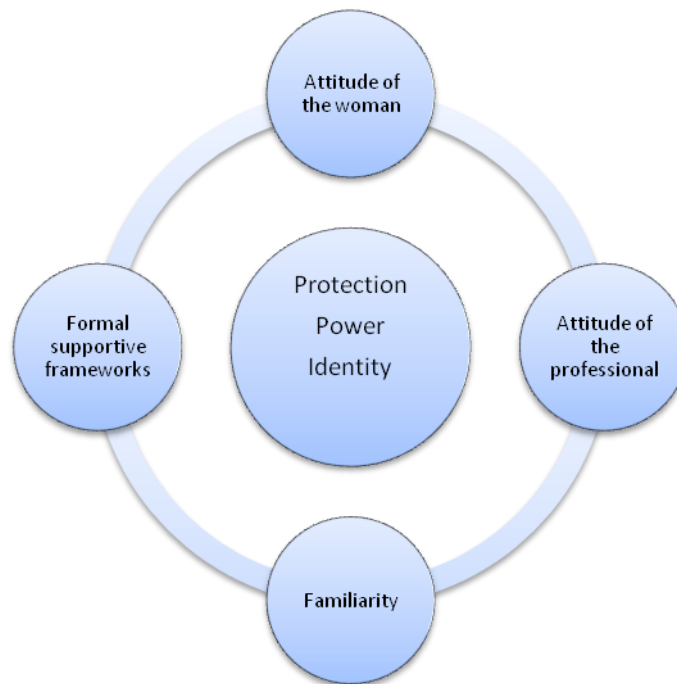
Chapter Eight: Discussion and the Disclosure Triad

In Chapters Six and Seven I aimed to set out the developing findings of the study, through the initial understanding prior to analysis and then to the deeper, emergent themes. In this chapter, I demonstrate how the themes can be interpreted at a more complex level into three core theoretical concepts, with their associated aspects, which help to achieve the aims of the study. This was achieved through a return to the methodology and further engagement with the data, this time analysing the five themes in the context of all of the dialogues; in other words, getting back into the hermeneutic circle. The interview data were analysed through a lens of disclosure with the dialogues being interrogated from that perspective. The women raised many different points that could have been explored further as being relevant to midwifery and to women's experiences of maternity services. However, this focus on disclosure meant that not all of these were explored in detail although some will be touched upon in this discussion chapter.

From the findings chapters it can be seen that a number of issues were raised in relation to disclosure generally, and disclosure of sexual orientation specifically. A number of important areas of discussion were evident. Some of these were specific to the individual participant but some were shared across the group; for example, invisibility was a strong theme within the literature but limited in the findings, whereas *being upfront* is largely absent in the literature but pervasive

within the narratives. Five themes were identified as discussed in Chapter Seven. Through the use of the iterative interpretation of the *hermeneutic circle* and the attempt to ‘fuse’ the nine horizons (the eight participants and me as the researcher) the three key concepts were extrapolated from the data (Fleming et al. 2003). These concepts – *protection*, *power* and *identity* – were developed in an attempt to categorise the apparently diverse experiences in a way that demonstrated an internal and external consistency. In reviewing the aims of the study, these outcomes related to the first two aims which were: to explore the motivation behind and purpose of disclosure of sexual orientation in pregnancy; and to explore the practical and psychosocial consequences perceived by lesbian women as a result of the decision to disclose. The mediators or factors that support disclosure relate to the third aim of the study: to consider the factors that support or moderate disclosure and the circumstances in which it occurs. Four mediators were identified: *the attitude of the woman*; *the attitude of the professional*; *familiarity*; and *formal support frameworks*. These mediators surround the themes and concepts, enveloping them in a supportive structure that provided the context in which disclosure would occur. The concepts and mediators are represented as a conceptual framework of disclosure in Figure 4.

Figure 4: the conceptual framework of disclosure



The concepts represent an end point in the analysis of the whole data set and therefore I have not made any attempt to rank them in any order of importance. Instead they are presented as a matrix of issues with complex relationships. *Protection* is discussed as a multifaceted concept that encompasses a dual purpose: protection *from* and protection *of*. Protection was both outward looking and inward looking, and was at times seen to be particularly important, for example protection against others making decisions contrary to the wishes of the women by excluding their partners. The second concept, *power* in the form of empowerment, is well known within midwifery discourse but in this discussion takes on a new perspective not evident in the literature. The woman as a source of empowerment for midwives is absent from discussions in mainstream

midwifery thinking but it was evident in each of the interviews. To this end, disclosure was the tool of choice for the women. The taking and giving of power was a strong theme that permeated the interview data. The final concept, *identity*, was another multifaceted concept that faced inwards, outwards and off into an unknown future. It was a complex concept with intrinsic and extrinsic meaning for the participants. It also had quite an important link to the concept of protection.

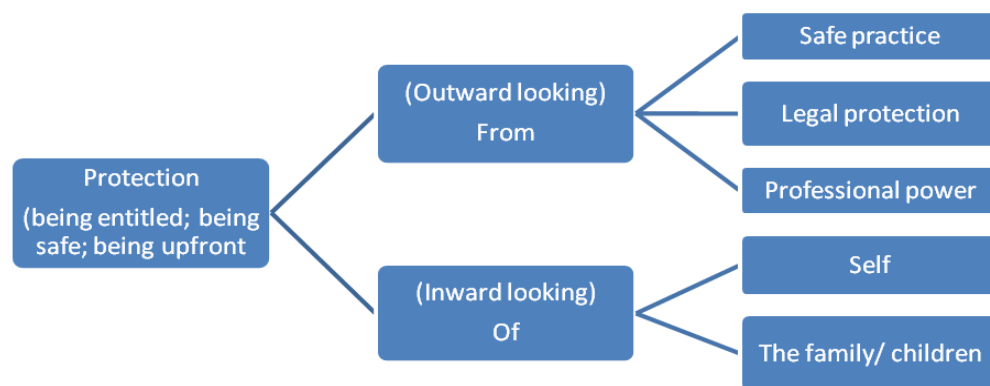
Also included in this chapter is a discussion of the findings in relation to the third aim of the study: the mediators of disclosure. These factors were not sought explicitly during the interview stage but extracted from the individual narratives related by the women. It was apparent that these mediators were related both to individual and organisation factors. Their importance in relation to maternity care practice will be discussed further in Chapter Nine, implications for practice, policy, education and research.

Protection

The concept of protection has been chosen to describe best those findings which indicate that the women in the study used disclosure as a way to ensure a safe environment in their experiences of pregnancy and maternity care. In Chapter Two, increased vulnerability was identified as a consequence of disclosure. Within this thesis, disclosure is also seen as a way of managing this vulnerability,

by being undertaken as in tandem with entitlement to care. Entitlement to care was not a prominent feature of studies within the literature review, and this is perhaps evidence of changing attitudes in an increasingly consumerist society. This concept of protection relates to the themes *being upfront*, *being entitled* and *being safe*, and is represented in the concept tree in Figure 5.

Figure 5: The concept of ‘protection’



Safety is not a word that the participants within the study used but it can be applied to a range of issues that arose within the dialogues. ‘Protection’ was used in a number of the interviews, but with different meanings for different participants. The diversity of issues within this concept resulted in a complex category in which the interplay of concern for self, and others, led to layers of meaning which are discussed here. The discourse of protection is used to discuss both proactive and reactive processes undertaken by the women during their pregnancies and beyond. These three layers are: safe practice; protection in the

context of legal complexity (including protection against professional power); and the protection of the children in the future.

Safe practice

In Chapter Three, I discussed the concept of safe practice in the context of disclosure and history-taking in clinical care. The issues raised within this discussion are reflected in the experiences of the women who participated in the study. From the interviews the prevalence of concerns for good care and a positive experience was not surprising. High quality clinical care is a stated aspiration of all health professions and also a requisite element for all those who access health services. It is an expectation, particularly in maternity care where good outcomes are generally anticipated. Professional knowledge and research is designed to ensure that professionals can meet this clinical obligation. As discussed, patient safety approaches to the management of care have been posited as a priority in recent years (NHS Scotland). These are based on the premise that measures can be put in place that will eliminate or reduce risk in relation to clinical decision-making by removing the element of human error. A significant resource has been allocated to the provision of patient safety initiatives within the National Health Service. An important aspect of this systems approach to safety is the obtaining of relevant information. This is fundamental to the decision-making process, particularly in relation to the use of clinical algorithms. Although midwifery depends largely on clinical judgement in normal

pregnancy and labour, algorithm approaches through clinical protocols are a recognised feature of the service where the pregnancy deviates from normal or where emergencies occur.

The introduction of standard documentation is increasing across health care services with, for example, Scottish Early Warning System (SEWS) charts, Essential Skills Clusters (ESC) and standardised maternity records (Scottish Woman-held Maternity Record or SWHMR) becoming commonplace. The ESC and the SWHMR are both currently unevaluated tools and the extent to which they improve outcomes and opportunities for 'invisible' groups of women, is uncertain. They do, however, indicate a desire by the maternity services to address the individuality of women, despite their standardised approach. An important example is use of the word *partner* and reduced emphasis on marital status. The limitations of such documentation lie in the context in which they attempt to address this individuality. If lesbian women do not feel that the environment is a safe one then they might not disclose their sexual orientation which then limits the assessment of the woman's needs. One key issue here is that the approach is open to interpretation by the midwife or other health care professional who can view the initial consultation through a heteronormative lens, expecting that the individuality will lie with marital status rather than sexual orientation. The way that the information is sought and the ability of the midwife to convey what the women describe as '*being diverse*' will perhaps influence the woman's comfort in disclosing.

It is evident from the findings in this study that the women were keen to take proactive steps to ensure that good care was given. They did not necessarily trust that the right information would be sought and they all knew that it would be easier to fit with expectations. For them, however, this was not an option and they all disclosed their sexual orientation before they were asked. Some did this before they were pregnant but generally they took the initiative because they knew that they were part of a minority group made invisible through pregnancy. Increasing visibility is categorised in Chapter Two under the consequences of disclosure. In this thesis, however, it can be seen as motivation for disclosure. The issue of safety was apparent even when disclosure took place. The confusion created by Karoline's pregnancy calls into question the value of information if the interpretation is flawed.

Legal protection

It was not surprising that the legal ramifications of lesbian motherhood would arise within the data. Interesting, however, is the way that it was related so clearly to the women's decisions around disclosure of sexual orientation. I might have assumed that one of the reasons for non-disclosure would have been perceived legal vulnerability and this might well be the case but in this doctoral study the women were generally well informed about legal status. Even where they were uncertain of the detail (probably owing to its complexity) they were aware of the issues that the law raised for them. They did not simply discuss it as

a general or side issue but as embedded in the decisions they made around disclosure. Again, the meaning applied to legal aspects varied across the interviews but broadly was recognised as something over which the women had limited control. Disclosure was one of the ways that they could exert some control in this area, at times because they did not trust the midwives and others to be well enough informed. Alison was the only participant who did not discuss legal rights to any great extent although even she identified the problems faced by health professionals in relation to the social mother's right to consent for the child's treatment.

Within the literature review of Chapters Two and Three, legal consequences of disclosure were not evident. Even although legal protection for sexual orientation is comparatively new, legal ramifications of disclosure seemed less important in the literature reviewed. The reasons for this can only be surmised but the most likely reason is that the outcomes of the disclosures related to individuals (Jourard 1971a; Markowe 2002; Griffith and Hebl 2002) whereas in this study the focus was on next of kin and consent for care given to family members.

The role of legislation for families of same sex couples is important because it can protect the family or make it vulnerable. The inconsistency of the legal picture for same sex couples was seen to cause problems because of the lack of coherence. Lesbian motherhood and the families of same sex couples are

regulated from a number of different directions and certainly within the timeframe of the women's experiences this regulation could be contradictory although some clarity now exists within the Human Fertilisation and Embryology Act 2008 and the Adoption and Children (Scotland) Act 2007 .

The introduction of the Civil Partnership Act 2004 led to formalisation and legal recognition of same sex partnerships, affording rights equivalent to marriage in most areas. Where a couple have decided to form a civil partnership their next of kin status is protected in relation to most aspects of life. The children of the family are included within this legislation but the legal role of the biological father causes the situation to become more complex. Children are deemed to be *children of the family* where they are the biological children of both parties - a situation rendered impossible for same sex couples – or where the child of one party is treated as the child of both. This then affords the child protection of the family; however, it does not transfer the parental rights for the child to the non-biological parent. Adoption or an order for parental responsibilities and rights would be required for such a transfer for rights⁷ and adoption cannot take place until after the birth of the child and, generally, without the transfer of parental rights by the biological father⁸. This is now possible under the Adoption and Children (Scotland) Act 2007. Where sperm from an unknown donor is used this

⁷ An order giving the social mother parental rights and responsibilities can also be made where there is a biological father with parental rights, effectively giving rise to three parents.

⁸ Courts can, however, overrule the wishes of the father, granting adoption without consent if it is deemed to be in the best interests of the child.

issue is less complicated because donors do not have parental rights or obligations for the children born from the donated sperm.

However, the issues for women in the study related to uncertain legal status, confusion about legal responsibilities (by both women and health professionals) and an assumption that health professionals would not know the legal position. Consent for treatment for the children and also for the partner was an important issue discussed within a heterosexist context. The need for the partner to prove rights was a strong theme whereas the recognition that *any* man in the context of childbirth would be deemed to be the husband was used as a way to illustrate the strength of normative assumptions and the fragility of the rights of the lesbian partner. Recognition of rights and roles seemed to be problematic and questioned by professionals. This set up a power relationship between the professional and the women and showed the vulnerability of the couple in relation to legal rights and protections. What Karoline and Karrie suggest as the way forward is a simple acknowledgement by staff that they 'get it' in terms of the relationship and the associated rights. The couple were less concerned with the more qualitative aspects of the experience than they were about being able to articulate their situation and for that to be heard and understood.

Disclosure of the relationship was accompanied by firm assertion of rights, and both of these elements were used to provide a safe environment for the family. Taking the initiative in the context of maternity care encounters meant being in

control of information and leaving nothing to chance, as it were. This was a motivation behind initial and continued disclosure. The fact that there was so much confusion about rights and roles within the women's experiences illustrates that legal complexity is often not part of the skill set of health professionals, nor is it always clear to those affected to whom it actually applies. It was only Karoline and Karrie who asserted what they believed to be their rights in relation to consent for the children's immunisations. In all other cases the birth mother was happy to accept that she was legally obliged to sign for consent to immunisation, at least on the first occasion. They appeared to do this because they believed it would be the same for heterosexual couples although Daryl acknowledged that this might not apply where the couples are married. The acceptability of restrictions imposed on their actions varied as expected but consistency with heterosexual couples did seem to be a marker for acceptability.

For a lay person seeking clarification of legal issues the process is notoriously difficult. Information might be difficult to find, the searcher might not know the language to use for searching purposes, access to formal legal advice can be expensive and online resources, even produced by reputable organisations, might not reflect the complexity of UK legal provision and variations across the legal systems. For large organisations such as the NHS, however, there are obligations to understand the legal position as it applies at the specific point of care delivery. The NHS is very good at addressing and communicating discrimination issues in relation to sex, race, disability and even sexual

orientation, but there needs to be greater awareness of the detail of delivering diversity-competent care.

Professional power

The concept of professional power and the women's vulnerability to it fits well within the context of the impact of legal factors. Conception is normally a private act that is only partially regulated by the law through, for example, age limits for sexual intercourse. There is very little interference in the private sphere of the family unless there is evidence of risk to children. However, for the women in the study conception required more of an active approach, and for those women accessing fertility treatment it was a much less private endeavour. This left them feeling open to scrutiny and more vulnerable to control through the use of 'professional power'.

The term 'professional power' is being used here to indicate the type of influence and control that could be exerted not by the law but through the decisions made by those in positions of responsibility relating to the process the women were undergoing. This was particularly the case for those women using formal sperm donor facilities but applied in other situations as well.

The issue of vulnerability to professional power was identified by almost all of the participants. Bernadette and Daryl were subject to legal intervention by the donor for access which left them powerless and feeling vulnerable. It was this

powerlessness against the legal rights of the 'father' that made them choose an anonymous donor with their second child. Although current legislation would mean that donors can no longer be anonymous, the power to seek that identity lies with the child and not the donor. In a doctoral thesis exploring kinship in sperm donation, Speirs (2007) suggests that, during and following the change in the law, concerns about identity moved to increase protection of the donor rather than the child. Access to identifying information in relation to the donor might in fact address the identity issue for children without increasing legal vulnerability for the family. While there might be issues for the donor, it is likely that the families created using donor sperm might be the ones to benefit.

In Anne's case, she felt, speculatively, that she and her partner were more thoroughly scrutinised during the fertility treatment phase. She discussed the fact that they had undergone counselling to ensure they were fit to be parents and she initially stated a belief that this was linked to their status as a same sex couple. She later moderated this response to indicate that it was the case for all women undergoing fertility treatment. The latter situation is in fact true and comes from a requirement within the Human Fertilisation and Embryology Acts of 1990 and 2008 whereby recipients of donor gametes are assessed using the principle of the best interests of the child. The wording from the particular (but anonymised) fertility clinic can be seen in Appendix IV. Anne did make the point that she and Diane would potentially make better parents than a heterosexual couple who had never had to give any thought to getting pregnant. She argued

that if she and her partner had encountered negativity around her pregnancy they would have referred to their commitment to this pregnancy. Anne illustrated this saying:

“[...] we kind of felt that if we got any negative feedback we’d make the point that we spent three years trying to conceive a child whereas other people can go out and conceive a child that night[...].”

She hoped that their openness and deliberate decisions they had made around pregnancy would provide protection against a decision not to allow them access to treatment.

Jenna already had experience of the impact of professional power. Her partner’s children had been subject to intervention by the police and it had been felt at the time that the children’s wayward behaviour was the result of the family structure. Jenna felt that she needed to be seen to be a ‘good lesbian mother’ so that her children would be protected from those who had power over her family. This would include health visitors, social workers and teachers. For her, honesty and an upfront approach was likely to lead to the best outcomes for the family. Also, having a well developed family structure including father involvement also made her feel that the family would be seen in a better light even though this was irritating for her. External scrutiny was seen as both unwelcome and inevitable. Given the significant body of research in relation to the psychological

and social wellbeing of children from lesbian families (Golombok and Tasker 1996; Weeks et al. 2001; Golombok et al. 2003a; Golombok et al. 2003b) Alison's sense of scrutiny seems a reasonable conclusion for her to draw. It was, in fact, Alison's awareness of this body of research that made her nervous about embarking on pregnancy although it was, ultimately, what helped her make the decision to do so.

The children

The third area considered under the heading of protection is protection of the children. In this study there were concerns expressed by the women about problems that their children might face from others (not only peers) because of their family background. The effects on children of growing up in families with same sex parents are much discussed in the literature and there is speculation as to how detrimental this might be. For example, there is a body of research in the field of child psychology that has demonstrated that gender development is a complex process involving role models from a range of sources (Maccoby 1988). Psychological development is not seen as occurring in a vacuum but involves a range of social influences (Golombok et al. 2003a). Interestingly, a significant majority of the work carried out into the wellbeing of children of same-sex couples actually relates specifically to lesbian mothers. Although this reflects the majority of same sex parenting it is in no way unique to lesbian mothers. This lack of research is likely to be related to the small numbers of same-sex families

with two fathers however the focus on lesbian mothers in the literature does tend to isolate them in this issue.

Golombok et al. (2003b) point to the various theoretical perspectives that predict a range of outcomes in terms of child development but show that a number of differences in parent-child relationship relate more to family structure (specifically single parent families) than to sexual orientation. However, they do point to a non-significant trend in relation to the Peer Problems Scale for children of lesbian parents. Their findings come from the Avon Longitudinal Study of Parents and Children (Golombok et al. 2003b). The Avon study included a total of 14,000 family members, 39 of which were from lesbian mother families. Only 11 of the children had not been born within a heterosexual relationship, with the average age for the remaining children of becoming part of a lesbian family being 4.1 years. The reported trend in relation to peer problems is a particularly interesting finding because it was reported by the mothers on the Strengths and Difficulties Questionnaire (SDQ) but was not reported by the children. The SDQ is a validated 25 item tool designed to assess the psychological wellbeing of children aged three to sixteen (Goodman 1997). It explores both positive and negative outcomes, thereby producing a more balanced overview of the child. However, when completed by the parents it can only produce an outsider perspective.

A linked research study using some of the same participants (Stevens et al. 2003) also identified mothers' concerns about bullying as being reasons for reluctance for (or concern about) disclosure of their sexual orientation and use of donor insemination to their children. However, a study of adolescent peer relations of the children of lesbian parents showed that the relationship issues were similar for young people regardless of family structure (Rivers et al. 2008; Wainright and Patterson 2008).

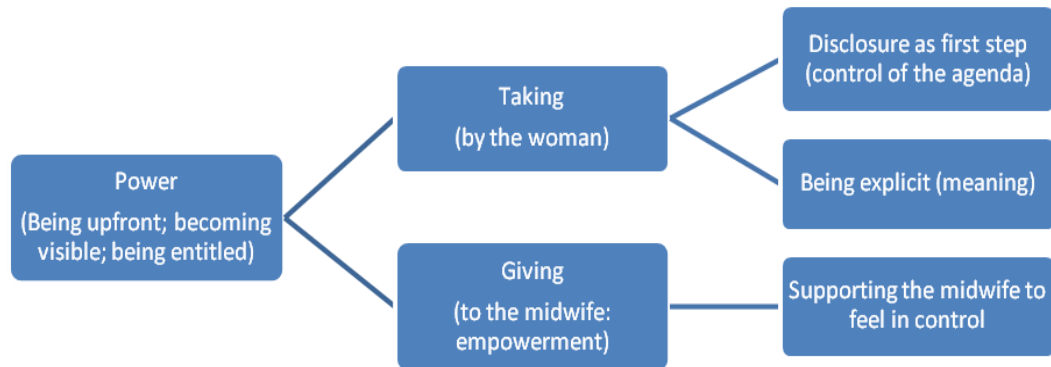
An in depth discussion of the outcomes and theoretical perspectives in relation to child development in lesbian families is beyond the scope of this thesis which aims to explore the women's experience. However, the issue is relevant to this study because the participants were clearly aware of the possibility of problems. Both Jenna and Anne said that disclosure was their way of ensuring that their children were protected through the nursery and the primary school's awareness of the family situation. However, Anne also expressed uncertainty about the way that her son Stewart would be treated when he moved to secondary school. Alison expressed the fear that Ben would be bullied because of her decisions but she also used disclosure as a way to test the water. Jenna used disclosure in this context to identify the areas of risk to enable avoidance. In Stevens' et al. (2003) study secondary school was also identified by participants as an area of worry and uncertainty. However, 28 of the 38 lesbian mothers in their study had conceived in heterosexual relationships. Those lesbian mothers who had undergone donor insemination disclosed earlier to their children because the

absence of a father was an early indicator to children. Although that study related to lesbian mothers disclosing their sexual orientation to their children, the tensions are similar. Disclosure was almost unavoidable but also carried with it a degree of risk.

Power

The second concept discussed here is that of power and how it was used and experienced by the women in the study. The tree in Figure 6 representing the power relationships was designed to illustrate the way that the concept of power encapsulates particular elements of the themes *being upfront; becoming visible* and *being entitled* discussed in Chapter Seven.

Figure 6: The conceptual ‘power’ tree



While I was first listening to the interviews and analysing the dialogues I was aware of the content as I was listening to the words. This was where I found my initial understanding which provided a baseline for further analysis. However, it was not until I had analysed and read and re-listened that I started to hear the issue of power in the narratives. This finding was one of the clearest moments in the thesis process where I felt I was hearing something new and I wrote this on a scrap of paper beside the bed:

*“Empowerment: central tenet of midwifery and seen as **being from the midwife to the woman**. Choice, continuity and control. But here the women express their reason for disclosure as being a form of empowerment **of the midwife!**”*

The concept of protection is one that was articulated explicitly but the concept of power is one that has been extrapolated from the context of interactions with midwives, or indeed other professionals the women encountered.

As a health professional, and a midwife in particular, the concept of empowerment forms the daily rhetoric of midwifery discourse and is a concept with which I am very familiar (if not entirely comfortable⁹). Fawcett et al. (1994) define empowerment as “*the process of gaining influence over events and outcomes of importance to an individual or group*” (p.471). The importance of that event or outcome is determined by the individual person or group and is therefore already defined by the group being empowered. In midwifery literature and midwifery practice the context of the empowerment is often defined by the professional. Matthews et al. (2006) offer an example of this context of empowerment in midwifery as being how midwives say that they provide woman-centred care and woman-centred care is a midwifery concept.

Empowerment in midwifery is a concept that is rarely, if ever, explored critically in relation to what it actually means for women, or as a concept over which users of maternity services have control. Empowerment implies a power imbalance. In

⁹ While empowerment is seen as a positive trait of midwifery whereby the woman is given power by the midwife, the concept is premised on the assumption that the midwife is the only holder of power. It is not possible to empower unless a situation exists where one person has power and the other does not. The woman and the midwife should be in positions of equal power where each has something to offer the other.

healthcare and midwifery there is a tendency in the literature to identify the woman (the service user) as powerless and for power to be *given* to her by the health professional through information, choice, control and informed decision-making (Janssen et al. 2009; Leap 2009). There is also a significant body of literature exploring empowerment of nurses and midwives (Lewis and Urmston 2000; Matthews et al. 2006; Matthews et al. 2009; Ning et al. 2009). All of this literature recognises the importance of empowerment and the effects of power imbalance (between professional and client or within the professional hierarchy or between qualified and student practitioners) and also the way that empowerment is used to increase satisfaction. Where there is a deficit of literature is in relation to the way that the woman is a holder and user of power in the context of episodes of care, particularly in midwifery.

In this study the concept of power can be divided into two dynamics: taking control (by the woman); and giving control (to the midwife) and encompasses all five of the themes discussed in Chapter Seven. The women discussed the ways in which they used disclosure to take control or the way that disclosing their sexual orientation gave them control. It was for them important information that they gave to the midwife so that the midwife would use that information to provide appropriate care: *woman-centred* care. However, unlike many of the women described within the literature, these women were not passive in the process of woman-centred care but in fact took the initiative in presenting the information

that they themselves felt was significant rather than waiting to be asked the right questions.

Taking control (by the woman)

In the dialogues there is evidence that through the giving of information women were able to take control. Not only did they take control of the information that was given by them but they also controlled the information that was withheld. They did this through choosing who to disclose to and how much information to provide. There was no uniformity of this approach but there was consistency of disclosure. One of the aims of the study was to explore the motivation behind disclosure and taking control seems to be an important part of that motivation. Although I did not ask the women direct questions about why they chose to disclose their sexual orientation, each of the interviews came round to this issue fairly early and the women talked about the need to be upfront. By being upfront the women believed they could moderate the responses of the health professional through the acknowledgement that the midwife might need to know. It was hoped that this would make the midwife feel that she had not been misled and had the necessary information to provide appropriate care: in other words it was empowering the midwife to provide high quality, woman-centred care.

This concept is similar to findings in a Scandinavian study by Spidsberg (2007). In her hermeneutic study with six couples disclosure of sexual orientation in

pregnancy was viewed by the women as an episode of caring; not caring by the midwife but by the woman. The participants felt a responsibility to enter the client/midwife relationship with the right attitude and that meant being open but not aggressive. The purpose of this was to allay fears and deal with uncertainty on the part of the midwife owing to the frequent lack of familiarity with lesbian mothers and their needs. In addition to this, the women disclosed so that doctors and midwives would know they existed. They did it as a political act to raise awareness of the fact that lesbian mothers were a growing user group in maternity services. However, they also disclosed having sought out safe environments through the careful choosing of their care providers.

This resonates with Steele et al. (2006) and Mulligan and Heath (2007) where participants sought safe environments for care. This seeking of sympathetic carers as a precursor to disclosure can be seen as another form of taking control or it could be viewed as a protective mechanism. In the current study the women seemed to find themselves in safer clinical environments because they were generally accessing maternity care from parts of the system that were already familiar with lesbian mothers. This was sometimes serendipitous rather than planned. For them the issue of disclosure was about setting the agenda and giving the midwife the opportunity to provide the right care. It was about being upfront and 'getting in first' so that the women did not have to rely on a system that was fundamentally heterosexist to recognise the existence of lesbian mothers. They did not want to wait to be asked in case that opportunity never

arose. Røndahl et al. (2009) suggest that if midwives were more effectively educated in the issue of lesbian motherhood then their language could be moderated to provide a more neutral and less heterosexist environment for disclosure. The women in my study were going beyond this in recognising the lack of education on this issue and working on an assumption of heterosexism within the system. Not waiting to be asked because of not expecting to be asked meant that they were taking back the control in terms of the exchange of information.

Giving control (to the midwife)

The concept of giving control to the midwife comes from my argument that in this study the empowerment in midwifery was reversed by the women so that they used the power that they had to give control to midwives in the provision of effective care. Jenna states her belief that people need to feel in control of the information that they require to fulfil their role and that withholding information about sexual orientation would be to put the midwife in a position where she could not provide appropriate care. The women felt it was important that because they knew their own sexual orientation and they recognised pregnancy and maternity care to be heterosexist and heteronormative then they had a responsibility to give that information to the midwife. In a reversal of perspectives the midwife was the one in the position of relative ignorance. If the midwife had guessed at the sexual orientation of the woman then she could have been seen as making assumptions based on appearance or presence of

another woman. From the midwife's perspective this would be a high risk strategy and the women recognised that fact.

The concept of knowledge as power is one that is well known in the literature. Foucauldian philosophy explores the way that the holders of knowledge are deemed to be the holders of power (Foucault 1978) and information is used throughout midwifery practice to help women find the power to make decisions about care. Ignorance is a way to hold power and Marxist theory would also offer this as a political truth. In Marxism the ignorance of the proletariat in relation to their role in capitalism is the way that the bourgeoisie keep control and take power (Marx 1888). This is not a new idea but is rarely applied to the way that those in positions of presumed powerlessness can actually use the same dynamic between knowledge and power to give a degree of control to others in order to achieve an improvement in their own experience.

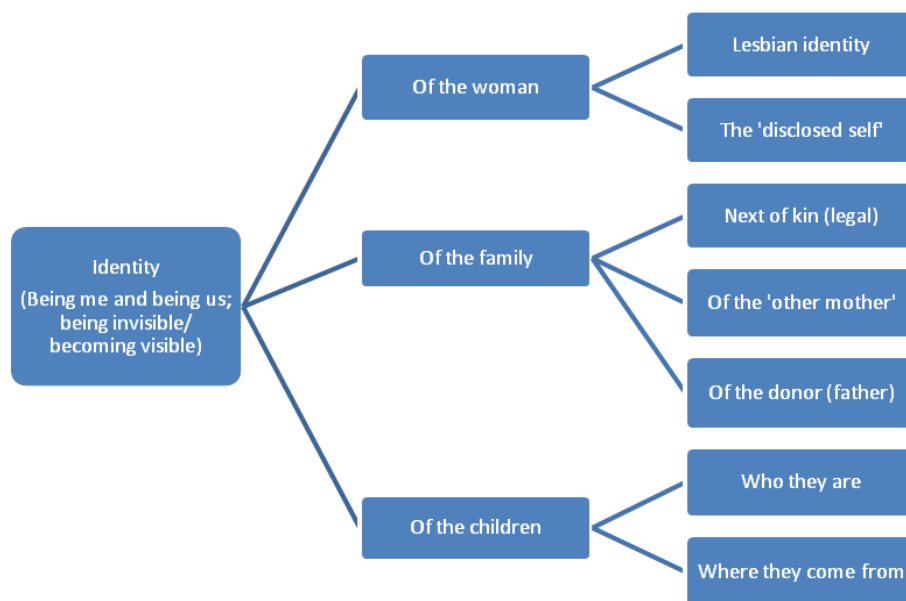
It is disingenuous to suggest that there is no recognition of service user knowledge in health care as there is a well developed concept of the client as expert. The Consumer Professional Partnership Program (CPPP), for example, uses consumer-driven lectures to teach professionals to care for people with spinal injuries (Kroll et al. 2008). This again is about acknowledgement by the health professions that service users have knowledge about their own health conditions. Although often driven by support groups particularly in relation to chronic illness there is a sense that health professions are somehow allowing

(enabling) service users to participate more directly in their own care (Department of Health 2001). It is, however, an important step forward, and will be revisited, later in this chapter, in relation to transferability.

Identity

The final set of concepts within the disclosure triad relates to identity and to the themes *being me and being us, being invisible and becoming visible*. Within this top level concept are three sub-levels: identity of the woman; of the family; of the child. These are represented in Figure 7. Identity has always been a key element within the disclosure literature, and was indeed an antecedent and consequence identified in the concept analysis.

Figure 7: the concept of identity



The nature of identity within each of these levels is quite different, in particular the way that the women ascribe meaning to these aspects. The identity of the woman is about personal identity as a lesbian within a heteronormative context and so is very personal to her. However, the identity of the family is about the recognition of the relationship the woman has with her partner, and that her partner has with the children. This is more of a social definition of identity and is important for midwifery practice because it is about meeting the needs of an emerging family, ensuring the experience is equivalent to that of any other family and that relationships are understood. The final aspect of identity is again very different. This relates to the importance of the genetic identity of the children: either the importance of knowing it or ways to manage this lack of knowledge.

Identity of the woman

In Chapter Two, I discussed the importance of identity in relation to disclosure. Initially, as part of the doctoral process, I spent a great deal of time exploring identity in relation to sexual orientation because I suspected that this would be one primary finding in the study. Although the women in the study did not focus on identity to the anticipated extent, they expressed its importance in a range of ways. Jenna was clearest about the importance of identity as *queer* during pregnancy and as a mother. Jenna used the word *queer* as an expression of diversity in a broader sense than just being lesbian. She used it to express her

belonging to the wider LGBT community: a community of difference. Being pregnant or being with the children made her identity as a lesbian woman invisible because of the social assumptions applied to mothers.

All identity is dependent on social context and individual perception. It is thereby socially constructed and fluid (Gray 2005). Gray (2005) identifies the concept of the *continuous self* which is recognised by the individual through a sense of comfort and familiarity. An individual perceives themselves as separate from others and this recognition enables their identity to be continuous despite changing circumstances. For Jenna, finding herself in a situation where she was not able to perceive herself with this sense of recognition caused her distress. The only way to be *queer* and to be a mother was to disclose that to others. In symbolic interactionism it is argued that self is also continuous but evolving through the use of dialogue with others and a view of the individual from the perspective of those they meet (Elliott 2005a). It is, in other words, about interaction between individuals through a mutual understanding of relevant symbols. Language and symbols are used to create a dialogue between individuals in social groups. The symbols we use are understood in the same way by all the members of the group, for example feeling sad when someone dies. Language is a necessary part of this as it enables the symbols to be accessed. Without language there is no symbolic understanding. In relation to disclosure there is a need for social interaction to define self. Self evolves from and is defined by the continued social dialogues and interactions between individuals

(seeing ourselves as others see us). This begs the question, what happens to the self when for some individuals this dialogue cannot take place as might be the case for lesbian mothers who, unlike Jenna, do not feel able to disclose? As Elliott (2005a, p.26) put it:

“To possess a ‘self’ then necessarily implies an ability to take one’s actions, emotions and beliefs as a unified structure, viewed from the perspective of significant others, as others would view and interpret actions of the self. Seen from this angle, the self is a social product through and through, an outcome of social symbolic interaction – of emergent, ongoing creation, thinking, feeling, the building of attitude structures, the taking on of roles, all in a quest for coherence and orientated to the social world.”

Disclosure, both verbal and written, became the way that women could express their identity as lesbian mothers. This sociological theory of self and identity places social interaction as the prime determinant of identity. However, the individual has a role to play in this social construction of identity through the engagement of the ‘I’. The ‘I’ is the subjective part of the self which has its own responses to social interaction and can adapt identity accordingly (Forgas and Kipling 2002). In the case of this doctoral study, the women could be seen to be engaging the ‘I’ in interactions through taking the initiative and at times changing identity to suit the social situation. Alison provided a good example of this when

discussing her relationship with her GP. Even though Alison had been referred by her GP for fertility treatment, the GP continued to refer to Alison's husband or Ben's father during consultations. Alison was happy enough to let the GP presume heterosexuality rather than enter into a reorganisation of identity. Alison was able to inhabit two completely different identities because the 'I' could accommodate both.

Jourard (1971a) focuses on the idea of the disclosed self as being related to health and wellbeing. Although he suggests that humans have a tendency to maintain a level of mystery in order to protect themselves from criticism, he also believes that being masked leads to poorer health.

"We camouflage our true being before others to protect ourselves against criticism or rejection. This protection comes at a steep price. When we are not truly known by the other people in our lives we are misunderstood. When we are misunderstood, especially by our family and our friends, we join the 'lonely crowd'. Worse, when we succeed in hiding our being from others, we tend to lose touch with our real selves. This loss of self contributes to illness in its myriad forms." (Jourard 1971a, p.viii).

Alison used the camouflage because it was easier to adopt a heterosexual identity than to be lesbian in the context of motherhood. For Jenna being lesbian was core to her identity and she needed to find ways of expressing that identity.

In both cases, and indeed in all of the women, identity as lesbian was important. Disclosure was the tool which they all used in the same way, to *be upfront*, but not in every situation.

Identity of the family

Another assumption that I brought into the study was that the women would disclose their sexual orientation in order to include their partner and, as discussed in Chapter Seven, to some extent this was true. However, identity of the family was a stronger concept, with identity of the partner being only one part of this. The women talked about wanting to have the support of their partner because this was something they needed and was something that heterosexual women would be able to access routinely. As discussed in Chapter Four, Helen was clear that pregnancy was about her and that it was a selfish process during which she wanted to be able to have her needs met. Only Karrie and Karoline spoke strongly about the need to have each other recognised as the partner and therefore the next of kin. This was less about the qualitative aspects of pregnancy and more about consent, control and legal protection.

However, there was a strong sense that disclosure would lead to recognition of the family as a complete unit, as is the case with families with heterosexual partners. Weber (2009) argues that nursing and social policy are failing to recognise the decline in the nuclear family, or more specifically the increase in

what he calls sexual minority families, and are not meeting the specific needs of these families.

For me, one of the most interesting aspects of this study has been the role and recognition of the social mother. In recent years there has been an increased focus on the role of the father, during and after pregnancy. Effective fatherhood is increasingly being seen as essential to stable family and social structures and the role of the father in supporting breastfeeding is being seen as an important public health issue (Stremmler and Lovera 2004; Kiernan and Pickett 2006; Ingram 2008). Family structure and long term health of children, and therefore the population as a whole, continues to be a focus of health care policy with interventions being developed to support and develop the role of the father in promoting health and wellbeing. The nature of this role – the father – is not explored in health literature. It is a taken for granted social norm. Whether the role of social mother can be substituted into the research is arguable and so the important role of the lesbian mother's partner is completely ignored.

A simple search in CINAHL using the keyword 'social mother' brings up one result which is a doctoral thesis exploring the effect of miscarriage on both the birth mother and the social mother. The same search using 'father' brings up 2398 results, relating to a range of health and parenting issues. Attempts to modify the search to find the hidden social mother were unsuccessful. Using *birth mother* resulted in 17 articles relating variously to adoption and to multiple birth,

and using *birthmother* only seven articles were retrieved, all of which related to adoption. It is not clear how to interrogate the literature to find the social mother in lesbian families and so it is not clear exactly how much work has been undertaken in relation to this group of women. It is clear, however, that there is not a large body of research, or even policy, relating to social mothers and their role.

This is not only an experiential issue. The lesbian mother will receive antenatal, intrapartum and postnatal care in the same way as any other woman, whether or not she discloses her sexual orientation. She will also be able to access antenatal education. All of these interventions are deemed important for a healthy pregnancy outcome. However, unless the family is identified as such and the role of the social mother is recognised in the same way as the father's role then interventions aimed at supporting the woman through her significant other are likely to be missed. Alison and Karoline both identified the antenatal education classes as being problematic for their partners. The midwives running these classes appeared unable to do so with the flexibility required to accommodate a social mother. As Karrie says, they were even unable to modify their language appropriately. They did not refer to *husbands* but they did refer to *fathers*. This represents an important area for further research. Research relating to the way that midwives manage diversity, from the midwives' perspective, would be a valuable way of exploring the professional/client dynamic from both sides. I am always aware that this study represents only one half of the dyad.

It is interesting that despite increasing recognition of same sex couples and their rights, there has not been a corresponding increase in the recognition of their roles in parenting in the nursing and midwifery literature. Research exploring same sex families is extensive but generally relates to the wellbeing and psychological development of children in these families, often with an emphasis on the development of gender roles and sexual orientation (Golombok and Tasker 1996; Golombok et al. 2003a). Although such research demonstrates that children of same sex families develop in the same way as children with opposite sex parents, the focus is on the child (the outcome measures relate to the child) and not the parents. In addition to this, the research lives within sociology and psychology. The key issue for lesbian mothers (and their partners) accessing maternity care is that the relationship is recognised by midwives and other health professionals that they encounter. They need midwives and others to acknowledge them as they are and to be explicit about recognising the family. Weber (2006) agrees that health professionals should *convey* their understanding of diversity in family structures rather than simply being aware of such diversity.

It was important for the participants that the family be recognised by others, not just health professionals, because they wanted their children to feel that the family was accepted. Jenna felt it was important that at the nursery and the school the children would be able to draw pictures of their family, and that these

representations would be accepted in the same way as the other children's families would be. The women felt it was important for the wellbeing of the children that their own family identity be seen as normal by others and so they took steps to assess the attitudes of others in advance. Karoline illustrated this very well when she said:

"[...] it is important that we get the recognition as family part too, even more so when you've got an older child around who's calling you mummy and mamma and...You know it's important for her that she sees that we're recognised by those health professionals too."

This focus on the happiness of the children through identity links with the final element of the identity leg of the disclosure triad: the identity of the children.

Identity of the children

It is not surprising that the women focused heavily on the wellbeing of their children as most parents have the wellbeing of their children at heart. While the women expressed concern about the family being recognised so that the children would feel that they were 'normal' in the wider social context, the genetic identity of the child was the more prominent issue. Karrie, Karoline and Jenna all used known donors so that the children would either know or have the chance to know their genetic background. Helen, Alison and Anne all discussed regret for the children at not being able to know their genetic background or find

the identity of their donor, but used other supportive approaches to address that deficit. Helen talked of a strong family resemblance, Anne spoke of how her son looked exactly the way her son should look and Alison spoke about replacing this missing part of identity with love so that her son did not feel deprived. They also talked about an important benefit of having used an unknown donor being that the family would only ever be the children and their two mothers. This was particularly significant for the social mother who would never have to compete with DNA. Only Bernadette and Daryl had the experience of both a known and an unknown donor. The issues were somewhat polarised. There was the importance of the children knowing their identity but this was balanced by the importance of protecting the family.

The evidence in relation to the need for children to know their genetic identity is variable but is different from the evidence relating to child development in same sex families. This is, after all, about genetics and knowledge delayed until after child development is complete. The debate leading up to the amendment of the Human Fertilisation and Embryology Act 1990 presented a range of perspectives but the strongest reason for changing the law was the need for the adult child to know their identity, primarily for medical reasons and for a sense of their own wider identity. The right of children to find out the identity of the donor also impacts on the parents' rights to withhold from their children information about donor conception. In the past parents have avoided disclosing to children for a range of reasons, including the fact that the child would be unable to find out

their genetic inheritance (Jadva et al. 2009). This, however, is no longer the case for children in the UK. Jadva et al. (2009) explored the experiences of children born from donor gametes, particularly in relation to disclosure of their genetic status. They found that the earlier children were disclosed to the less detrimental the effect. Very interestingly, when asked how they felt about the disclosure, those disclosed to below the age of three were excluded because they would not have remembered how they felt. This is interesting because the answer, even coloured by the passage of time, could have given an important insight into how they *believed* they felt. Participants in the study expressed their main response in terms of curiosity and significantly more children in the later disclosure group experienced negative emotions such as shame than in the earlier disclosure group (Jadva et al. 2009). It has also been shown that lesbian mothers tend to disclose earlier than heterosexual parents because the absence of a father, and also often the presence of two mothers, makes this more obvious to the child anyway (Stevens et al. 2003). This suggests that the children born to lesbian mother from donor sperm, rather than in an ostensibly heterosexual relationship, are more likely to feel positive about their donor status because they tend to know from a younger age.

Kirkman (2003), in a research study undertaken before the change in the law, explores the way that parents contribute to their children's constructed identities (narrative identities) when conceived with donor sperm, and identifies a continuum of disclosure from concealment to involvement from birth.

However, the literature on gamete donation covers the range of recipients of donated gametes, for example, infertile (male or female) heterosexual couples, single mothers, and lesbian mothers. The reasons behind using donor gametes vary across groups and the feelings of the parents in relation to needing donated gametes vary also. The narratives in relation to identity chosen by the parents for their children must take into account the social responses in relation to those identities (Kirkman 2003). Infertility can be humiliating, particularly to men, while deliberate single parenthood can be seen as irresponsible. Disclosing to the child the circumstances of their conception means creating an identity for the child and the family with which the child then has to live. In my study the women all created narrative identities of warm, loving families who had made very positive decisions to have children.

The women in this study felt that their children had a right to know who they were, or at least to know they were conceived through donated sperm. Alison in particular felt a great responsibility towards Ben and his social and psychological wellbeing. She did not want the decisions that she made to impact negatively on this child whom she believed she had 'selfishly' chosen to have. She felt she could not have more children because their right to access to identity existed whereas Ben's did not. All of the women wanted the best for their children and separated their own rights and political beliefs from the rights of their children.

The right to an identity is protected at an international level and although socially constructed it is seen as universally important. Article 8 of the UN Convention on the Rights of the Child affords children the right to an identity, which is defined fairly broadly:

“Article 8 (Preservation of identity): Children have the right to an identity – an official record of who they are. Governments should respect children’s right to a name, a nationality and family ties” (United Nations Children’s Fund 1989).

It is seen as important for wellbeing that the child has this identity both at a macro and micro level: in other words, as belonging to a nation (in order to have a formal identity) and belonging to a family (to have a social identity). Moving further into the micro (personal) level, in an editorial, van Kraayenoord (2010) touches on the growing social expectation of knowing ourselves and where we come from, and how this has been popularised within ‘Western societies’. In addition to populist television series on tracing family trees, there is also an exponentially growing market in the tracing of family history. Knowing who we are appears to be a strong human drive.

Donovan (2006) provides an interesting counter-argument in relation to the change in the 1990 HFEA. She suggests that this was the result of resurgence in the alleged social importance of a genetic relationship between father and their

children, and that this applies even more strongly in relation to lesbian families. The argument for allowing children born by donor insemination to discover their identity was ostensibly to enable children to access their 'genetic capital' and to gain better understanding about their potential futures: risk factors for health, mortality and morbidity. However, Donovan (2006) is arguing here that the law was changed not to meet the needs of the children but to support the continued social ideal of families with fathers: a way to achieve "social order by reproducing heteronormative families" (p. 495). Although a powerful feminist argument it must be tempered by the acknowledgement that the provisions of the Human Fertilisation and Embryology Acts apply to donated gametes and include donated ova. Donovan's argument also fails to resonate with the women in this doctoral study. The right of the children to find out their own genetics was something asserted by the women as being important, and regret was expressed on behalf of those children for whom this would never be an option.

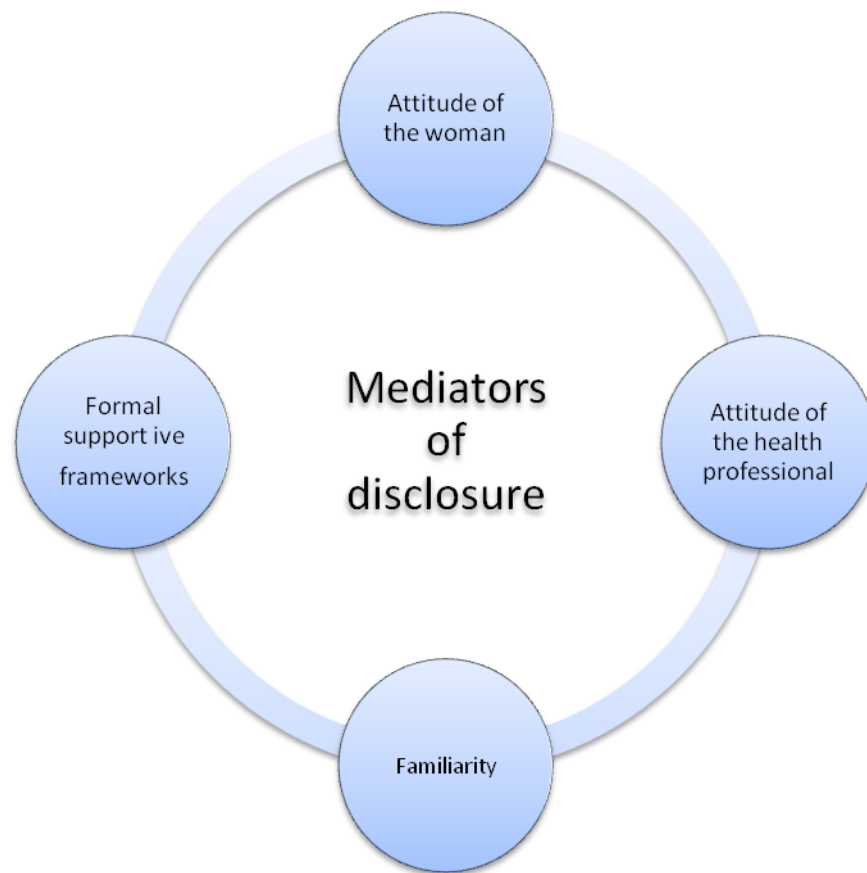
Identity is undoubtedly a complex and emotive issue. The needs of the child and the needs of the parents can come into direct conflict with society deciding what is in the best interests of the child regardless of the perspective of the parents. But identity in all its forms within this study only exists through disclosure. It is through disclosure that the lesbian mother exists within maternity care, that the social mother and the family exist, and the identity of the child as the offspring of donor conception, regardless of whether that child then seeks out their genetic identity. Disclosure is the key to all of this as otherwise the identity remains

hidden within the private sphere of being (which may or may not be the wish of the individual).

Having explored the three main concepts of disclosure and their constituent aspects I will now go on to explore the findings in relation to the third aim of the study: the factors that facilitate disclosure of sexual orientation in pregnancy.

Mediators of disclosure

Disclosure of sexual orientation was identified by all the women as potentially risky although not necessarily a problem. In a situation of risk individuals will weigh up the likelihood of a poor outcome in making a decision about an action and they will also look at the circumstances in which the action will take place in order to assess it as a facilitative environment. Although not explicitly identifying factors that promoted disclosure for them the women all talked about circumstances of care or characteristics of individuals that made them feel more secure in the belief that the consequences of their disclosure would not be negative. These can be categorised as individual and organisational and fall under the four headings: attitude of the woman; attitude of the professional (including reciprocity); familiarity; and formal supportive frameworks. They can be seen in Figure 8.

Figure 8: Mediators of disclosure

Chaudoir and Fisher (2010) suggest that very little research has been undertaken exploring the mediating factors for disclosure of what they term 'concealable stigmatised identities' but I would argue that their focus on the literature in psychology might be the reason for this. The research on disclosure contained in the psychology literature relates almost exclusively to outcomes of disclosure or consequences of not disclosing. Disclosure is seen as an important therapeutic tool that the therapist can use rather than an activity that might or might not happen and the reasons for that. Jourard (1971a) did suggest that women were more likely to disclose to women and that reciprocity of disclosure was

important. Beyond that, however, there is little exploration. However, although it is true that there is little research exploring these factors explicitly, it is possible to extrapolate from the findings of research into lesbian motherhood factors which mediate disclosure. In this doctoral study the mediators of disclosure were identifiable from the interviews and are discussed here.

Attitude of the woman

By far the most common mediator of disclosure was the attitude of the woman: attitude towards disclosure and her belief in her right to disclose. That they were going to disclose was taken for granted by these women and it is difficult to evaluate the reasons for this, given that none of the participants concealed their sexual orientation. Although some participants acknowledged that there might be less positive consequences of disclosure they never considered the option of *not* disclosing. All of the participants in the study came from stable, long term relationships and it is tempting to conclude that this was a factor in their attitude to disclosure. However, although the women pointed to this as being important in them being good parents and making an informed decision to become parents, they did not refer to it in relation to their decisions to disclose. Another possible influencing factor was the age of the women. The women were all in their 30s and 40s and had all come out at least ten years earlier, if not more. They also stated that they were out in almost all aspects of their lives. Given this fact it seems logical that they would have seen disclosure as a given.

However, even although disclosure was largely taken for granted by the women in the study this did not mean they felt militant about it or that they were not conscious of the potential to alienate health professionals through the way they chose to disclose. They were, in fact, very clear that disclosing was not about making a political statement but about being honest and frank. This is illustrated very clearly in an exchange between Bernadette and Daryl:

[Bernadette] *“But we’re not like that as individuals. We don’t do things for effect. We don’t stand up and say let’s fight for our rights and stuff. That’s just stupid. Whereas there are some that do.”*

[Daryl] *“Well we don’t make an issue of it.”*

[Bernadette] *“Well you don’t want people to feel awkward in your company and you want people to like you and your children for who you are as a family unit...”*

This is echoed in Dibley’s study (2009) of lesbian mothers’ interactions with health care professionals. Participants in her study also discussed how they managed the process of disclosure in ways that would not be perceived as making a political statement but instead were simply about identifying the family structure in order for the right care to be given. Spidsberg (2007) also found that lesbian women felt a responsibility for having and displaying the right attitude in their encounters with health professionals by being honest but not aggressive

about their sexual orientation. Being confident in their sexual orientation and feeling confident in the situation made them more likely to disclose. In both Dibley's (2009) and Spidsberg's (2007) studies the participants had all disclosed their sexual orientation although in those studies, as in mine, disclosure was not a prerequisite for participation. It can be concluded that the attitude that they had in choosing to disclose to health professionals was the same as the one that made them agree to participate in research and so the findings are subject to disclosure bias. This is explored further in the limitations section of this thesis.

Attitude here has not been identified simply as a result of the women having disclosed but instead derives from the context in which the women disclosed and the way that they express coming out in a broader sense. It is not possible to speculate about the women who did not disclose because they did not participate in the study and I would not like to draw conclusions suggesting that there were differences between the groups. The point that I am making here is that the women in this study, all of whom disclosed, viewed disclosure of sexual orientation with a particular sense of disclosure being taken for granted.

From a policy or practice perspective it is difficult to see how this very personal quality could be influenced through changes in practice as attitude and confidence is a feature that the person brings with them and which has developed over their lifetime. Underlying social factors that have resulted in a particular approach to disclosure need to be extrapolated and encouraged within

healthcare but that would not be possible from this data as it was not the focus of the interviews.

Attitude of the professional

The attitude of the professional was a very interesting, although not surprising, mediator of disclosure. The women in the study talked about disclosure with the G.P., health visitors, fertility nurses, community midwives and hospital midwives. In each of these occasions the women talked about the characteristics of the professionals to whom they had chosen to disclose but also the responses to disclosure. Bernadette and Daryl described one of their midwives as being 'very diverse', having come up from London. This midwife was seen to be practising in a way that made visible her open-minded attitude. However, it is also true that Bernadette and Daryl had already disclosed their sexual orientation so the attitude of the health professional was not a factor for disclosure. It was, instead, a factor in their interpretation of their experience as being positive. The midwife's attitude helped give them confidence to behave as a couple and relax. It is not clear what the midwife did that brought the women to the conclusion that she was open-minded, but they seemed intuitively to recognise a different characteristic, perhaps in her responses or her language. The women do not provide an explanation.

In a Canadian study, using quantitative data to explore predictive factors in access of healthcare by lesbian women, it was found that factors relating to the

professional were more likely to predict disclosure of sexual orientation than the extent to which the individual women were 'out' (Steele et al. 2006). Perceived attitude of the professional and also whether the health professional asked questions were predictors of disclosure to a greater extent than the attitude of the women themselves. In fact, questioning about sexual orientation led to 100% of disclosure in this study. Disclosure of sexual orientation was also associated with greater uptake of health care. As Steele et al. (2006) conclude, such a finding suggests that health professionals can take positive action to encourage disclosure and uptake of health services.

McDonald (2008) suggests that it is only when the health professional shows themselves to be free of assumptions that those who are not heterosexual can extract themselves from the categories of heteronormativity in order to disclose themselves and aspects of their life. Her discussion is contextualised in the therapeutic nature of disclosure in mental health practice. Disclosure is seen as something essential for health but disclosure of individual factors that are not normative can also be seen by the individual as threatening so the context must demonstrate safety. This creation of safe environments is echoed throughout the literature on sexual orientation and health care (Wilton and Kaufmann 2001; Jackson 2003; Mulligan and Heath 2007). This all assumes, of course, that the individual health professional is actually open to difference and is actually willing to provide a safe environment for care. This (absence of homophobia) is the precursor for signalling open-mindedness and is actually an issue that is not

extensively addressed in the literature. Participants in Dibley's (2009) study felt that midwives were allocated to them, by the midwife in charge, on the basis of their acceptance of lesbian families. They also suspected that midwives who were less comfortable manoeuvred themselves out of the situation of caring. This is not particularly seen as a problem by women, including the women in my study, who felt that they did not want to be cared for by someone who did not approve.

Interestingly, there is an element of reciprocity in these interactions. Both Alison and Daryl discuss encounters with lesbian midwives, or in Alison's case the lesbian student midwife. The midwives seem to have disclosed their own sexual orientation in response to the women's disclosures. In Bernadette's case there is some speculation that the midwife allocated to their care was chosen because of her sexual orientation. This appeared to be a response to their previous difficult experience. Their second experience of maternity care was certainly much more positive but the reason for that was multi-factorial. If, however, a lesbian midwife were allocated to their care as a deliberate move to promote a positive experience it would suggest that the culture was such that lesbian midwives felt safe to come out. It does seem clear from Alison's experience that this was not necessarily the case. It is also an inadequate response to diversity to allocate midwives on the basis of their own diversity status.

Reciprocity is a feature of disclosure discussed in Jourard's original work (Jourard 1971a) where he suggests that disclosure leads to disclosure from the recipient. It is a factor in the development of trusting relationships but is also a controversial issue in healthcare. It could be argued that the woman who discloses is looking for an acknowledgement or a positive response or indeed no response at all. But disclosure is not necessarily an invitation for reciprocity. Within midwifery education one of the greatest challenges for students with personal experience of pregnancy is to extract themselves from these experiences so that the care they provide is centred on the woman and not on the self. Having said that, participants in Riordan's (2004) study of lesbian, gay or bisexual health professionals suggested that reciprocal 'coming out' was often used as a way to demonstrate sympathy and understanding in order to engender trust. Both Alison and Bernadette give examples of the midwife coming out as lesbian following their disclosures. Given the positive outcomes of disclosure for the individual (Chaudoir and Fisher 2010) reciprocity of disclosures (openness, not necessarily of sexual orientation) seems like an important aspect of care to promote.

Familiarity

Familiarity here refers less to a personal familiarity than to the familiarity of the professional context of care with the diversity agenda; specifically in relation to lesbian women seeking fertility or maternity care. Each of the participants made reference to the extent to which their health professionals had experience of

working with other lesbian mothers and how they felt this impacted on their care. In some cases the women specifically chose GP surgeries or teams of midwives whom they described as 'gay friendly', using their own networks to identify such professionals. Research by Mulligan and Heath (2007) concluded that women who identify as not being heterosexual access care from medical professionals carefully, choosing those known to be sympathetic. Their recommendations for practice are that those health practitioners should work to signal their openness to sexually diverse groups. This is an interesting response in that it encourages the creation of safe spaces for people from sexual minorities instead of being a critique of the social factors that lead to the marginalised experience of this group of health care users. Such an approach addresses a symptom of prejudice rather than the cause although it is a legitimate approach for the promotion of inclusion.

It was apparent from the interviews that the women experienced good care in environments with experience of working with lesbian mothers. The women who accessed the services of the fertility clinic had generally positive experiences with the exception of Alison who felt that she was treated less well than other women seeking fertility treatment. The nurse providing information made Alison feel that she should consider herself lucky to be receiving any treatment at all, never mind concern herself about choice of sperm. The nurse might have been the same with a single woman seeking sperm donation but that is impossible to know. The women did not necessarily have to make a first disclosure with the

fertility clinic as this was generally on the referral letter from the GP. However, they felt that non-verbal disclosures (being a couple, holding hands, involvement of the social mother) were more comfortable in environments of clinical familiarity. Linking back to Ward and Winstanley (2005), disclosure and familiarity enables the woman to increase the subject positions available to her, by increasing the understanding of those who provide these contexts of care.

Community midwifery settings were also seen more positively. Continuity of care and carer is more usual in the community, and the women developed good relationships with their community midwives. Jenna in particular felt this was essential because she had two home births. She could not have concealed the fact of her family set up. She had the same team of midwives with her second pregnancy, and this made further disclosures unnecessary. The importance of continuity of care, one to one midwifery, and the development of a therapeutic rapport are all recognised within the midwifery literature as being important (Green et al. 2000; Huber and Sandall 2006). However, Green et al. (2000) conclude that continuity itself is not seen as important for women, unless they have experienced it. What is concluded in both these examples is that trust is vital for the therapeutic relationship. What the women in this doctoral study were experiencing was a relationship with health professionals whom they trusted. The contexts in which trusted care was given were those contexts involving familiarity, either with other lesbian mothers or with issues of diversity.

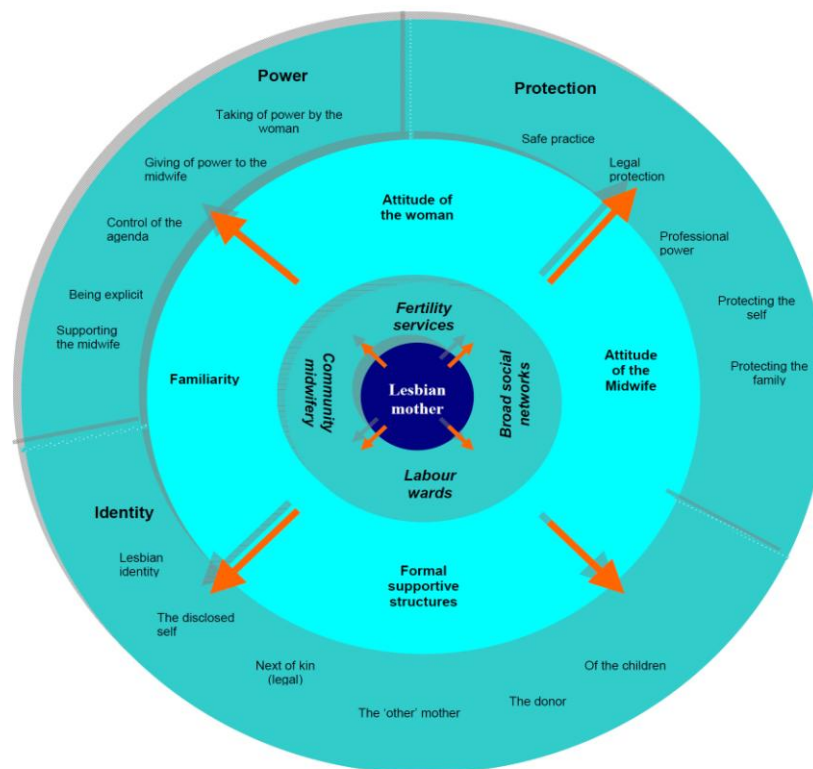
The women experienced more problems in brief or one off encounters with health professionals. This included the radiographer, an operating department practitioner, and, more importantly, care received in the hospital setting during labour and postnatally. They often put this down to stress amongst the staff but also to lack of familiarity with lesbian parents. This lack of familiarity and contact with lesbians having children seemed to result in uncertainty on the part of the professionals involved.

The lack of familiarity appeared to lead to discomfort on the part of the midwives in particular and this, coupled with workload issues, organisational stresses and what Alison believed to be a bullying culture, the care they gave to the participants appeared at times to be substandard. As discussed in Chapter Three, midwives who come under organisational pressure will replace the *with woman* model of practice with a *with institution* model (Hunter 2004). Hunter's (2004) discussion of the *with institution* model suggests that midwives will adopt this approach as a way to manage organisational stress and it could be that the midwives in this doctoral study did not believe they had the skills to care for the women and so adopted an institutional approach. However, it is hard to conclude from Hunter's work that this would lead to *poor* care. Standardised, 'production line' care might be expected but substandard care would not. It cannot be ruled out that this level of professional performance resulted from homophobia and in this regard it would seem that little has changed since Wilton and Kaufmann's work a decade ago (Wilton and Kaufmann 2001).

The final conceptual framework

Using the contexts of disclosure identified by the women, the mediators of disclosure and the consequences, Figure 9 shows the relationships of these factors.

Figure 9: The relationships of disclosure



It is clear from the diagram that the woman (lesbian mother) is at the centre of the process. The second circle represents the various contexts of disclosure identified by the women as being relevant to being pregnant or having children. The arrows represent the woman moving into these contexts. The next circle holds the mediators of disclosure: formal supportive structures; familiarity;

attitude of the woman; and attitude of the professional. When the woman encounters these mediators then this leads to disclosure, represented by the larger arrows. This disclosure leads to the outer circle containing the three domains of the outcomes of disclosure.

With reference to the concept analysis in Chapter Two, it can be seen that the elements identified from the literature review are evident within this example of disclosure. The principal antecedent of disclosure is having something to disclose and that in this case that is minority sexual orientation. There needs also to be a reason, desire and motivation to disclose. In the case of this research study, minority sexual orientation was disclosed because the women felt it was part of their identity or it was necessary in order for their partner to be seen. It was also seen as important for ensuring that the care received was safe and appropriate. Its consequences were to increase visibility and identity, but also to increase vulnerability depending on professional attitudes. Very little in the way of overt moral outrage was experienced but ambivalence was expressed, for example Daryl's colleague, and suspected homophobia was experienced.

The dynamic of disclosure – pro-action and altruism

I conclude from this discussion that a dynamic of disclosure exists, whereby the women disclosed with reference to two motivators: pro-action and altruism. *Being invisible and becoming visible*, and also *being me and being us* are strong

themes of proactive disclosure, used by the women as a means of being seen as a lesbian mother but more importantly as a same sex family. But there is altruism in the disclosure as well, as the disclosure makes the social mother visible. The social mother is the least visible group of parents, having no clear role other than supporter, unless she is made visible. The processes involved within the theme *being upfront* are proactive steps that enabled the woman to take control of information but this is also an altruistic step as it gives control to the midwife. The theme *being entitled* strongly supported the notion of pro-action. The women used the security of the entitlement to disclose, using their rights as protection and feeling secure in asserting those rights. They used the protective legal frameworks to provide a context for disclosure but were also demonstrating altruism in giving the midwife the opportunity to treat the women well. In the theme *being safe and being careful* it can be seen quite clearly that the women used disclosure proactively to ensure safe and appropriate care was given by the relevant health professional.

Pro-action and altruism seem to work together with pro-action as the primary motivator and altruism as secondary. This is similar to Spidsberg's (2007) label of *caring* however I feel that caring implies a closer personal relationship than was evident in my study. Altruism is a concern for others that puts personal gain to one side and in this study involved a trade off between a desire for privacy and the benefit to others of disclosure. Jenna, for example, discussed the fact that she was happy to answer questions about her pregnancy, and in particular

methods of conception, because it broadened the knowledge base of the midwives. This, she felt, would benefit other lesbian mothers in the future if more people knew more about the issues involved in lesbian motherhood.

Limitations and reflections

Having considered the triad of concepts relating to the purpose of disclosure in the study, and those factors which mediate or facilitate disclosure, it is necessary to contextualise these within the limitations of the study. In the final section of this chapter I discuss the specific limitations of this study and reflect on the implications of these for the overall thesis, and also discuss the ways in which rigour was addressed. I do not see the discussion of limitations as setting out the negative aspects of the study process but a discussion of the challenges faced, the opportunities to learn and factors which influenced the evolution of the whole doctoral journey.

It is important to recognise that there are limitations in any research project and where these cannot be resolved they should be made explicit and contextualised within the research (Patton 2002). In addition to this, it is hard to imagine that the novice researcher would not encounter limitations or flaws in their research. Learning from the analysis of the limitations is an important part of developing research expertise, and revisiting these aspects of the study has been interesting. At this point it is not a case of simply looking for limitations and stumbling across

them. These are issues with which I have wrestled for many months, and which have required some kind of resolution, be that actual or philosophical. In this study there are two primary limitations: sample size and disclosure status. An additional limitation in relation to interviewing should also be mentioned here and will be discussed last.

Sample size

At the start of this study, my intention had been to interview approximately 20 women with a mixture of those who had disclosed and those who had concealed their sexual orientation to their health professionals in pregnancy. To that end I employed broad, inclusive sampling criteria with very flexible cautionary considerations. I wanted to optimise participation, and felt it important to be as inclusive as possible with this often marginal group. Twenty seemed a reasonable number given the nature of the interviews and the potential problems of access. In the end, despite considerable effort on the part of my participants and me the sample size remained small.

Although the sample size was less than anticipated this is not necessarily problematic. Firstly, the study is qualitative and therefore will never be representative of any group, nor was that the intention. The purpose of the study was to explore the concept of disclosure through the paradigm case of lesbian mothers, but it was never intended that findings would be generated which would be generalisable to the total childbearing population. Patton (2002)

argues that sample size is a variable facet of research and its sufficiency depends on the researcher's aim: breadth or depth. Breadth would involve a larger sample size but depth can be obtained with a smaller number and I believe that this is the case in this study. The use of unstructured interviewing led to thick data which explored a number of pertinent issues which were relevant across the group or specific to the individual.

Important in this as well is the fact that this study explored the experiences of an under-researched and often invisible group of maternity service users. It would be hard to reject this sample as being too small without suggesting that the voices of these women had nothing of value to add to the body of research in relation to disclosure, maternity care, or lesbian women's life experiences.

Disclosure status

The second limitation of the study is the fact that all of the participants had disclosed sexual orientation, despite that not being an inclusion criterion. The participants were keen to approach women whom they knew did not disclose sexual orientation to their maternity care professionals, but all declined to participate. This was a significant disappointment as I believed, and still believe, that there is a lot to learn from the women who do not come out to their caregivers. Given that the UK is seen as an increasingly tolerant society it is fascinating that not only did women choose not to disclose, but that they would not participate in the study either. This limits the possibility of comparing the

experiences of the women who disclose with those who do not but this was unavoidable.

Coherence

In the end, and following lengthy discussion, I felt that the sample of eight women was coherent and complete. The one response I had received from the national network was a mother of teenage children who had given birth in the North of England. Her context was so different to any of the other participants I felt that it would simply have provided an unrelated set of data. Because of the small sample size I felt that it was essential to consider the nature of the sample and to view these in terms of authenticity of the findings. I did this by considering this notion of coherence. The group of women who agreed to participate formed a coherent sample in the following ways:

- Disclosure status
- Location of experience
- Relationship status
- Timeframe of experience

Disclosure status

All of the women had disclosed their sexual orientation which meant that comparisons could be made across the participants in relation to their decisions to disclose, the circumstances supporting disclosure, the outcomes of disclosure

and the ways in which they disclosed. The iterative process of analysis and attempt at a fusion of horizons was at least possible because the horizons were from a similar perspective.

Location of experience

All of the women had their maternity care experiences in the same health board area. They accessed very similar facilities but their experiences of these same services were still different. Through engagement with the interviews and the developing themes, patterns became evident across the data. It was useful to compare the different ways in which the women had accessed the same service, and the responses they received at various points in the process. The coherent sample made it possible to draw conclusions about the structures that support and dissuade disclosure. From a methodological perspective, it ensured that meanings could be compared more effectively and the individual horizons were more closely aligned. Historicity is an important aspect of Gadamer's philosophy and so the proximity of time and place meant that the dialogues made more sense as parts and as a whole.

Relationship status

Because lesbian mothers by definition do not have male partners, it is just as easy (or difficult) to become pregnant in or out of a relationship. This might have offered a particular perspective in relation to decision-making and support for

disclosure. However, in this study all of the participants were in long term stable relationships, where both partners were comfortable with becoming a family. Given the small numbers this offers some consistency and credibility to the findings.

Timeframe of experience

There was no specific limit placed on the maternity experience of the participants, but the final sample had all had experiences within the last 4 years. Only one couple had an older child, ten years old, but they also had more recent experience of the service. Including the one additional participant would have introduced an 'outlier' where experience had occurred at least 14 years previously. Again, this would have impacted on the historical context of the experiences described and the process of comparing the parts with the whole would have been difficult in this case.

Interviewing

An additional limitation with the study is the issue of the development of interview technique. Unstructured interviews were employed for this study as it was appropriate methodologically and politically. I felt strongly that the agenda should belong to the women and so I aimed to limit my input. Listening to the interview tapes was a revelation for me as I heard at times quite directive questions which I believed I had not used. This was particularly evident in the

early interviews where I think lack of confidence in the approach led me to ask questions based on my own assumptions and pre-understandings. I made comments in my transcripts in order to indicate to myself where I felt that my questions had intruded. In later interviews I felt I became more effective in using the dialogical and conversational approach required with unstructured interviewing, but my first interviews were less successful in using this. Having made my pre-understanding explicit early on it was interesting being able to hear how these continued to influence the interviews but recognition of these understandings was useful when it came to interpretation and meaning.

Also, despite my best attempts to limit its impact, the presence of young children and the effect this had on the flow of the discussion and my ability to hear in order to transcribe was evident. Making reference to this in the transcripts helped me to work out where the wording was less reliable so I could look for confirmation of the meaning elsewhere in the discussion. In places it is my question which is inaudible which means that the context of the response at times has to be guessed but most of the issues were dealt with through repeated listening and contextualising with reference to the surrounding text. At the end of the day, hermeneutic phenomenology is not about the analysis of minutiae but about meaning in context. Those brief missing sections of dialogue did not reduce the overall meaning of the interviews.

From my own perspective, I feel that my understanding of interviewing and my own interviewing technique improved significantly. My attempts to facilitate dialogues through unstructured interviews improved over time. Managing the environment, however, was outside my control. Because all of the women had at least one pre-school age child it was virtually impossible to find a time or place where a child would not be present, and I did not feel it appropriate to ask the women to send their children elsewhere. On the one occasion where it was agreed to have the interview in the evening I had presumed this was so the child would be asleep. Instead she refused to go to bed, became very tired and, in fact, probably made more noise than she would have during the day. The fact that all of the interviews took place in the women's homes meant that I did not know the environment in advance, and it was difficult to organise them to optimise recording quality. I think this is probably a limitation of any study that aims to maximise the control retained by the participants. I was aware that I drew on my experience of parenthood to accommodate the disruption and at times vaguely chaotic nature of the interviews.

A further reflection in relation to interviewing is an acknowledgement that I found it an incredibly enjoyable but stressful experience. Going to interview strangers in their own homes was, I am sure, as stressful for me as it was for them. Giving up a degree of power by giving choice of location to the women

meant facing unknown situations with unknown people¹⁰ and attempting to establish trust and rapport in a very short space of time. My experiences as a labour ward midwife were helpful here as that particular midwifery role requires the ability to build a relationship with a stranger, in intensely stressful circumstances, but in a very short time frame. The fact that the women were trusting, welcoming and open was also, without a doubt, a factor in the success of the interview process. Given the nature of the topic under discussion, I was impressed by the honesty of the women and can only hope that they did not find the process overly intrusive. Emails following the interviews, as well as the women's willingness to pass my name to other women, indicated that this was indeed the case.

Ensuring rigour

Rigour, and the importance of demonstrating it, is a complex and contested concept in nursing and midwifery research (Rolfe 2006). Rigour is the attempt made by the researcher to provide reassurance that the research has been conducted properly and the findings can be relied upon (Patton 2002). While the processes for achieving this in quantitative research are well established, for example using statistical measurements and calculations to control variables, in qualitative research this depends to a large extent on the chosen methodology

¹⁰ In order to protect myself I ensured that someone knew which area I was travelling to and I kept my mobile phone with me at all times. I did not provide detailed information about addresses as this would have compromised confidentiality and I was not concerned about safety in the homes themselves.

and its underpinning philosophical tradition. While Murphy and Yelder (2009) argue for a structured approach to rigour in qualitative research, at least for the novice researcher, Rolfe (2006) argues a diametrically opposed position where there can never be a unified approach. Seale and Silverman (1997) provide analysis of a range of techniques which use systematic approaches to data analysis and transparency of rigour, almost verging on adaptations of quantitative techniques, which seems contrary to the qualitative aspiration to represent meaning rather than results.

Although the debate about rigour in qualitative research has raged on for some time, there is general agreement within the professions of midwifery and nursing that it is important to take steps to demonstrate that research is robust. In this section I will set out the different ways that I ensured the rigour of the study and the ways in which they helped achieve this.

Using a clear research method

For the purposes of this study I chose a particular methodology and established method to follow (Fleming et al. 2003). This enabled me to follow particular stages in data collection and analysis, and these have been described within Chapters Five, Six and Seven. The rationale for this choice was discussed in Chapter Four where I indicated that my approach had been adapted. This adaptation related to another approach for establishing rigour: participant validation (Bradbury-Jones et al. 2010). The small sample size and snowball

technique meant that it was very difficult, if not impossible, to ask for participant validation beyond confirmation of the transcripts owing to the real risk of breaching confidentiality. However, sections of transcripts and my initial understandings were sent to participants for confirmation that I was representing them appropriately. In addition to that, the interview tapes were returned to on a number of occasions, as a form of participant validation, so that I could confirm that I had heard them correctly. It also helped me to hear the tone of voice and other features lost on the page. It is also the case that the women were already reflecting on their experiences, generally with at least two years of hindsight.

Consistency and transferability

In order to ensure that the transcripts and findings were consistent, both of my supervisors were given copies of the interview transcripts, and both also reviewed the initial understandings and the findings chapters as they developed. This was important in providing assurance that my interpretation and conclusions were derived from the data. External consistency was also ensured through a constant return to the existing literature. Findings that were different from but consistent with other research, in relation to both disclosure and lesbian mothers' experiences, indicated that my findings were at least part of a small coherent body of research.

This links to transferability which can be described as the qualitative research version of generalisability (Polit and Beck 2010) since it is not the purpose of qualitative research findings to be generalised across populations. However, it is possible to demonstrate that the findings do not relate only to the participants within the study but could be transferred to other similar populations. In the course of my study I made an explicit attempt to test the transferability of the findings by sharing parts of my data and findings with another researcher working in a similar field. I made a trip to London to meet with Lesley Dibley who had presented outcomes from a study exploring lesbian mothers' experiences of having a child who needs medical care. This was an important and interesting opportunity where it was evident that she had found similar experiences among the women in her study. She went on to publish her findings soon after this meeting (Dibley, 2009).

The findings are also transferable across health populations. As discussed earlier in this chapter in relation to *giving control to the midwife*, there is a recognised role for users of health services to act as 'experts' in their care (Kroll et al 2008). The concept of the expert patient has developed somewhat over the last decade. In 2001, the English Department of Health published *The Expert Patient* programme (DoH, 2001). At the heart of this programme was the perception that health professionals knew less than patients, particularly in relation to long term conditions such as diabetes or epilepsy. The patient is described as 'an untapped resource' (p.5).

The concept of the patient as the expert is understandably not without its critics. Fitzpatrick (2004) is scathing in his discussion, asserting that the patient as expert is 'nonsense', and indeed suggesting it to be anti-professional. However, the involvement by service users is more a recognition that the individual makes sense of a condition for themselves, and best understands the impact it has on their own lives. This is not necessarily about understanding, for example, the physiology, pharmacology or medicine. Instead, it is about the individual understanding how the condition impacts on them and their lives, as well as the individual effectiveness of therapies. A defensive position by professionals is unnecessary because the role of the expert patient is to support professional practice rather than to undermine it. In the case of lesbian mothers, the expertise is in their sexual orientation rather than a long term condition. Their expertise is similar to that of women from minority racial or ethnic backgrounds. However, they are the experts in this aspect of their lives and can therefore support the midwife's professional practice.

Reflexivity, transparency and peer review

Part of undertaking this study has been making explicit my own personal stance in relation to the topic under scrutiny. I have been overt in stating my presumptions and pre-understandings, and have also documented my decision-trail throughout. I maintained a somewhat disorganised research diary, mostly in the form of Word documents with my developing thinking. I have been able to

refer to this to ensure that I have not strayed too far from the data itself. Rolfe (2006) argues that it is this reflexivity that ensures the quality of the research can be assessed by the reader, whose responsibility it is to judge that quality.

I have also presented my work on a number of occasions, thereby enabling its scrutiny by peers in the environment of international conferences. I presented the initial understandings at the ICM congress in 2008, the interpretation of negative experiences at the UCLAN international research conference in 2009 and also presented the rationale for the study to a national LGBT symposium in 2008.

Summary

In this Chapter I have discussed the many issues raised by the study as well as providing a conceptual framework relating to the way that the study has achieved the research aims. Relating the findings to the aims has enabled an analysis of their implications. Also in Chapter Eight I have set out the study limitations and discussed the different ways in which rigour was addressed.

In Chapter Nine the conclusions and recommendations for policy, practice, research and education will be set out. The study has demonstrated a complex interplay of motivations, outcomes and mediators for disclosure, and each of

these has implications for future practice. Where questions are as yet unanswered, future research will be invaluable in addressing this deficit.

Chapter Nine: Conclusions and Recommendations

"I think you need them to specifically and explicitly acknowledge that they've understood what your family structure is, which is a little different. I think you need them to show that they get that it's not just the assumed model. I think that's important. I'd like to see them change their paperwork to reflect that and to be more inclusive. You know, there's no big deal. It would be very easy for them to do but they don't. I don't know why. It would be a breeze wouldn't it." (Karoline)

Introduction

I decided to start this final chapter with this quote from Karoline. I found it again when I was re-reading the interview. It struck me very clearly as an eloquent expression of a core issue: it would be easy to change midwifery practice to reflect the needs of this client group and it is not clear why change is so slow. What Karoline is saying, and what this thesis has shown, is that changes could be made to facilitate disclosure of sexual orientation, and provide appropriate care in response to that disclosure with very little cost or effort.

In this concluding chapter I will review the aims and purpose of the study, summarise the thesis chapters, and identify the implications of the findings

including recommendations for practice, policy, education and future research. I also finish with a personal reflection now the thesis is complete.

The research question revisited

In order to contextualise my conclusions and recommendation I have reproduced, here, the research question and the research aims for the study.

Research question

What are lesbian women's experiences in relation to disclosure of sexual orientation in pregnancy?

Research Aims

- To explore the motivation behind and purpose of disclosure of sexual orientation in pregnancy
- To explore the practical and psychosocial consequences perceived by lesbian women as a result of the decision to disclose.
- To consider the factors that support or moderate disclosure and the circumstances in which it occurs.

An underlying aim of the study was:

- To increase the visibility of lesbian mothers in order to bring them from the margins to the centre of care.

All of these aims have been addressed. The research themes set out in Chapter Seven indicate motivations for disclosure, the outcomes for the woman and her family, and also those factors which support and promote disclosure. Disclosure of sexual orientation in maternity care settings was shown to be important and to have meaning for the women. A disclosure of sexual minority status has meaning, purpose and consequences which the woman expects will form part of her maternity care experience.

As illustrated in the discussions in Chapter Eight, the findings of this study supplement those findings of other studies, notably Wilton and Kaufmann (2001), Røndahl (2006), Spidsberg (2007) and Dibley (2009). This doctoral study adds to these findings the dimension of disclosure.

The findings of the study have been somewhat one sided in only representing the view of women who disclosed sexual orientation. This will always be a disappointment for me as it was an unintended outcome and I worked hard to avoid it.

A summary of the thesis

In Chapter One, I set out the background for the study and my reasons for undertaking it; both personal and professional. My aim in this chapter was to set out from the beginning the basis from which the study would be approached and

the personal reflections that would underpin the engagement with the dialogues generated through the interview process. I also outlined the concept of disclosure and its various facets. The purpose of this was to identify disclosure as both important and complex. Also, within this chapter, I explained the midwifery philosophy of woman-centred care and how that ideology underpins midwifery practice in the United Kingdom and other similar countries. This chapter also set out my justification for focusing on lesbian mothers as the paradigm case of disclosure in pregnancy.

In Chapter Two, I discussed the literature in relation to disclosure as a concept. The purpose was to explain further the elements of disclosure and its importance to health and to general wellbeing. This chapter also included a discussion of 'coming out' and the way that it was relevant within this study. I also discussed the importance of disclosure in establishing self and identity. In this chapter I hoped to establish disclosure as an important social activity with purpose and with consequences as theorised within the literature of psychology and sociology.

Chapter Three placed disclosure more closely within healthcare and maternity care settings. In this chapter I also discussed the existing literature on lesbian mothers and their experiences of maternity care. The use of information and standardised health records was also discussed, particularly in relation to the contradiction between standardised information and woman-centredness.

In Chapters Four and Five I discussed the methodology and methods for the study, setting out the methodological, ethical and practical issues in relation to undertaking the research. The characteristics of hermeneutic phenomenology were discussed and the methodological considerations in relation to this particular study, including how these were addressed.

Chapters Six and Seven set out the findings of the study. Chapter Six was an important part of the data analysis for this methodology as it involved setting out initial understandings, or first impressions, of the findings. The findings from this part of the study were presented at a major international midwifery conference and were referred to in the proceedings of the day (Lee 2008). In Chapter Seven I set out the findings following detailed analysis using the iterative hermeneutic circle. I attempted to identify the fused horizons essential to this methodological approach. Included in this chapter was a discussion of a particular outcome of the study; the way in which the women interpreted and made sense of negative maternity care experiences. This chapter was also adapted and submitted for publication.

A full discussion of the findings was presented in Chapter Eight. I identified the three main concepts derived from the data and their related aspects. *Protection*, *power* and *identity* were identified as the key elements of disclosure for the

women in the study along with a primary motivation of pro-action and a secondary motivation of altruism.

Implications of the study

Recommendations for practice

The majority of recommendations arising from this doctoral study relate to practice. There are a number of steps that midwives, and other relevant health professionals, could take to address the issues raised by the women and discussed in this thesis. The detailed recommendations for practice are discussed next.

The woman as an active participant in maternity care

One of the most important conclusions of this study is that women are not passive within the maternity care process, particularly in the disclosure of invisible factors. Disclosure was a proactive step in establishing the relationship with health professionals and providing an opportunity for that relationship to be a good one. It was both self motivated and altruistic. The implications for practice therefore fall under four headings: acknowledging the detail; recognising the existence of lesbian mothers; recognising the importance of the social mother; 'exploiting' the contribution of the woman.

Acknowledging the detail

The women in this study felt that disclosure was easier in contexts where the possibility of lesbian pregnancy was recognised. However, equally important was an explicit indication that the midwife, or other professional, understood the implications for same sex couples; both personal and formal (for example, legal). The more personal and experiential aspects such as inclusion of the partner at scans were important but insufficient. Lesbian motherhood was conceptualised as a real and important issue with consequences, and should be taken seriously.

Practice recommendations (acknowledging the detail)

1. Midwives, and others, should acknowledge sexual orientation as part of woman-centred care, make explicit their understanding of the personal and formal implications for lesbian mothers, and incorporate the woman and her family's individual needs into the plan of care.
2. Midwives, and other relevant health professionals, should be aware of next of kin issues, rights to consent and the rights of the social mother, particularly where civil partnership exists.
3. In a changing legal environment it is essential that midwives keep abreast of legislation and recognise how and when it applies.
4. Midwives should also modify language to accommodate diversity. Using 'partner' to acknowledge the possibility of same sex couples rather than just unmarried couples would go some way to

improving communication. Inclusive language that signals acceptance and enables women to disclose safely could obviate the need for concealment of sexual orientation.

Recognising that lesbian mothers are mothers

In previous studies the recommendations for practice have involved improved levels of education for midwives in relation to lesbian motherhood (Wilton and Kaufmann 2001; Jackson 2003; McManus et al. 2006; Dibley 2009; Røndahl et al. 2009), specific parenthood education classes for lesbian mothers (Røndahl et al. 2009), practising woman-centred care (Jackson 2003) and improved levels of communication (Wilton and Kaufmann 2001; Spidsberg 2007). All of these recommendations are relevant and important, but they will not in themselves promote disclosures. Without disclosure the lesbian mother remains invisible regardless.

At times, these recommendations can also further marginalise lesbian mothers, for example specific antenatal education for lesbian couples further separates this client group from the mainstream. This does not help to normalise or integrate lesbian motherhood. Also, improved levels of education for midwives will increase knowledge but it will not necessarily improve attitudes of staff. All health professionals have a legal obligation to provide equal care across all diversity strands. A change in attitude towards minority groups should

accompany this obligation. Midwives, and their colleagues, should acknowledge as an assumption, the expectation that pregnancy is heterosexual.

Practice recommendations (lesbian mothers as mothers)

1. Midwives should be open to the fact that lesbian women can and do become pregnant and so should facilitate disclosures.
2. Modification of language should not be about genericisation of care but a way of accessing women's realities. This language should be used to signal recognition of variety and not to homogenise care.
3. Once the woman has indicated her family relationships language should reflect the woman's chosen terms (including, for example, the use of the word *husband* for married women).

Recognising the importance of the social mother

There can be little doubt that the social mother plays an important role in her partner's pregnancy, in the same way as fathers do. Midwives' inability to manage this contribution seems uncharacteristically unresponsive. Public health and social drivers have meant that there has been an increased focus on fathers and fatherhood in recent years, particularly in relation to the promotion of breastfeeding. Antenatal education is also designed to address the needs of the couple along with the separate needs of the woman and the father. The social mother sits in an uneasy limbo.

Health and other professionals involved with the family need to acknowledge that if fathers are important to the health and wellbeing of the family then the social mother is equally important in this regard.

Practice recommendation (the social mother)

1. Midwives, and others, need to find *inclusive*, rather than *exclusive*, ways of accommodating the social mother in all aspects of the maternity care process.
2. Antenatal education should be flexible enough to accommodate diverse family structures so that the social mother (where one exists) can be included fully in the role of the woman's partner, her supporter and as the baby's other parent.

'Exploiting' the contribution of the woman

Key within this study is the part that women play within the disclosure process and the making visible of lesbian motherhood. The research in relation to lesbian mothers makes recommendations that only relate to midwifery practice. It fails to capitalise on the role that the women themselves play in the process of improving outcomes. It is not necessary for midwives to have detailed knowledge of all groups of women in their care if they are able to recognise that some women will have specific needs in pregnancy. Being able to articulate this understanding and ask, sensitively, relevant questions in relation to these needs

is a way of expressing the relative power of the woman in those circumstances.

With this in mind:

Practice recommendations (the contribution of the woman)

1. Midwives should acknowledge the woman as the expert, where appropriate.
2. Midwives should not mistake professionalism for omniscience but should seek knowledge from those who have it.
3. Following disclosure of sexual orientation, midwives should ask relevant and appropriate questions in order to meet the needs of the woman in exactly the same way as for heterosexual women. This requires the midwife to be informed.

Recommendations for policy

While many positive steps have been taken towards equality across the spectrum of diversity, particularly in relation to legislation, legal protection is only useful if those delivering care are aware that it exists and what it provides. Moreover, it cannot be presumed that the woman herself will be knowledgeable of the legal implications of her relationship. As can be seen from Chapter Eight, the legal implications of same sex families are complex and widespread. Health professionals should be able to refer to policy information to assist them to provide diversity sensitive care.

Policies aimed at enhancing the maternity care experience for women and their families should encompass the range of families.

Policy recommendations

1. Political policy makers should recognise the increase in sexual minority families and embed this diversity in maternity and health policy. This is particularly true of family health policy for example NHS Scotland's HEAT Target 7 (breastfeeding)¹¹.
2. Since organisations such as the NHS are responsible for ensuring that they adhere to equality legislation they should provide explicit written policies with appropriate supporting training for staff.
3. Standardised documentation used in maternity care, where family structure is relevant, should explicitly reflect diversity in families. Generic language with an underlying heteronormative meaning should be avoided and instead clear opportunities to identify a same sex partner should be available.
4. Policies stating broad organisational aims for equitable care are laudable but in order to ensure that legal requirements are

¹¹ HEAT Targets (Health Improvement, Efficiency, Access, Treatment) are NHS Scotland's strategic approach to tackling key health priorities. HEAT Target 7 aims to increase exclusive breastfeeding at 6-8 weeks postnatally by capitalising on, among other things, support of women by partners and grandparents.

met the policies should be just as explicit as those policies setting out to manage clinical care.

5. Where policies exist that make specific provision for women's partners and children, these should be developed with flexibility to ensure that lesbian mothers and their families are not excluded. In addition to this, policies that aim to set limits on the authority of the non-birth parent (including fathers) should be based in current law and not custom and practice.

Recommendations for education

Many of the educational recommendations resulting from empirical research in relation to lesbian mothers involve pre-registration midwifery education. This is important but fails to address the ongoing educational needs of midwives in this dynamic profession. Since 2009, all forms of diversity, including sexual orientation, are explicitly included in the Essential Skills Clusters and NMC Standards for Pre-registration Midwifery Education (NMC 2009). This means that all educational programmes designed to prepare midwives for registration will have to include teaching in relation to this.

Owing to the changing legal frameworks relating to diverse populations, it is important that education be ongoing for registered midwives. The obligation of midwives to update their knowledge and skills should include their understanding of the legal implications of a disclosure from a lesbian mother.

Educational recommendations

1. Midwifery educators should ensure that when teaching pre-registration students about the care of women from sexual minorities, both psychosocial and legal issues should be explored. These include legal consequences of civil partnership, same sex adoption, next of kin, and gamete donation.
2. Effective communication skills are an important aspect of this teaching, particularly in relation to the women's experiences of assumptions being applied.
3. Registered midwives should take steps to update their knowledge of the law and should practise in ways that promote the rights of all women in their care, particularly where these are explicitly protected by law.

It would also be essential that the effectiveness of the implementation of recommendations was evaluated.

Recommendations for research

A number of areas for further research arose from the findings of this study. The two principal areas relate to the social mother and the knowledge and attitudes of midwives.

The social mother

It is currently impossible to know the extent to which the roles of father and social mother are directly comparable. In other words, to what extent is gender a factor in the role of the father in promoting family health and raising socially adjusted children?

Research recommendations (social mother)

1. A recommendation for future research would be an exploration of the role and needs of the social mother and a review of current research on fatherhood to assess its applicability to evidence-based practice in relation to social mothers.
2. The contribution of the social mother, and the recognition of this role in parenting, should not be under-estimated but should be properly explored through research to optimise the experience of motherhood for this group of women.

Midwives

It is evident that there is currently little or no research on midwives' knowledge of and attitudes towards lesbian mothers. It is not enough simply to say that midwives must practise in accordance with legislation and inclusivity. This fails to take into account the experiences of midwives, instead silencing their voices with the legal frameworks. It is only through an exploration and subsequent understanding of the underlying factors leading to poor responses that the appropriate recommendations can be promoted.

Research recommendations (midwives)

1. Research should be undertaken exploring the ways in which midwives manage diversity in maternity care.
2. Research should be undertaken exploring midwives' attitudes to lesbian mothers.
3. In addition to this, quantitative research should be undertaken to establish the knowledge base of midwives in relation to the legal implications of lesbian motherhood.

Summary

In this chapter I have set out my conclusions for the study and provided four sets of recommendations arising from the research. I have addressed the research question and the aims. In this concluding section I would like to bring the

discussion together to identify how it adds to the existing body of research into disclosure of sexual orientation in maternity care contexts.

Disclosure has been shown to be a rational, planned and motivated act. It has also been shown to be an act over which women retain control. In addition to this, it is an act with outcomes and consequences, and when lesbian women disclose their sexual orientation the act has significance and meaning. It helps identify the woman, her partner and her family but it also signals to midwives and other health professionals that the woman expects the disclosure to be taken into account in her care.

The woman has also been shown to be a holder of power, who is not passive in her care but can take control of information that she feels is significant. Disclosure has been shown to be an act of empowerment that runs in the opposite direction than current theoretical perspectives in midwifery literature suggest. Because disclosure of sexual orientation has purpose and motive, recommendations can be made to promote this disclosure and the understanding of its purpose and consequences.

Disclosure in this context is real and has meaning. It enables midwives to provide care that truly meets the needs of the woman and her family. In addition to this, the strong sense of the social mother as a parent enables greater inclusion and

sensitivity to the role of the non-birth mother in the ongoing health and wellbeing of the family.

A final (very personal) reflection

When I started this PhD journey, I was fairly sure what I would find. I thought that lesbian mothers would have experienced negative responses to their disclosure of sexual orientation or would have been fearful enough not to disclose. I believed that I would get the stories of disclosure and non-disclosure and would be able fully to explore the issues and present some solutions. Some of this has come to pass and with hindsight some of it now seems extremely naïve.

What I did not expect, however, was the extent to which I have been changed by this journey. Not so much the research journey but the engagement with the lives of this group of strangers who were so completely honest and who gave me so much. I have never felt the privilege of midwifery as strongly as I did during the interviews. In the early days of my PhD one of my former supervisors told me that I should not aim to change the world with my thesis, but should wait until I was doing post-doctoral work. Looking back to that time, and looking forwards to beyond the PhD, I find myself thinking what is the point if I do not try to make a difference with my research? It is a small project but an important one and the women who gave so much of themselves in participating in this study have given me real insight into their experiences and their lives. They need their stories to be told so that one day no lesbian woman will have to hide behind the

heterosexism of pregnancy to protect her from prejudice. She will be able to disclose and to be herself.

This doctoral study has been a genuine attempt to increase understanding in relation to a small but significant (and growing) group of women who are, and shall remain, invisible unless they are free to be themselves and to tell their own stories. This is not about midwives (or other health professionals) and what we can do *for* the women. It is about the women and how we can learn *from* them.

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Appendix One: Ethics Approval Form

UNIVERSITY OF DUNDEE UNIVERSITY RESEARCH ETHICS COMMITTEE APPROVAL FORM

Title of project: An exploration of the experience of disclosure of sexual orientation in pregnancy.

Name of lead Investigator, School (or equivalent), Status (e.g. staff, student):

Elaine Lee, Lecturer in Midwifery and Doctoral Student, School of Nursing and Midwifery.

Other Academic Staff involved (e.g. supervisor, co-researchers): Research

Supervisors: Professor Sheila Hunt, Dean, School of Nursing and Midwifery and Dr Markus Themessl-Huber, Lecturer, School of Nursing and Midwifery.

E-mail address: e.c.lee@dundee.ac.uk

Date: 1st December 2006 UREC Ref no. (LEAVE BLANK):

		YES	NO	N/A
1	Will you describe the main procedures to participants in advance so that they are informed about what to expect in your study?	Yes		
2	Will you tell participants that their participation is voluntary?	Yes		
3	Will your participants be able to read and understand the participant information sheet?	Yes		

4	Will you obtain written informed consent for participation?	Yes		
5	If the research is observational, will you ask participants for their consent to being observed?			N/A
6	Will you tell participants that they may withdraw from the research at any time without penalty and for any reason?	Yes		
7	With questionnaires, will you give participants the option of omitting questions they do not want to answer?			N/A
8	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	Yes		
9	Will you give participants a brief explanation of the purpose of the study at the end of their participation in it, and answer any questions?	Yes		
10	Will your project involved deliberately misleading participants in any way?		No	
11	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g. who they can contact for help).		No	

12	Do participants fall into any of the following special groups?	Children (under 18 years of age)		No	
		Children under 5 years of age		No	
		Pregnant women		No	
		Participants studied with respect to contraception or conception		No	
		People with learning or communication difficulties		No	
		People in custody		No	
		People engaged in illegal activities (e.g. drug-taking)		No	
		Non-human animals		No	
		Patients		No	
	Note that you may also need to obtain satisfactory Disclosure Scotland (or equivalent) clearance.	More than 5000 participants			

Please tick **either** Box A **or** Box B below and provide any details required in support of your application. If you ticked NO to any of Q1-9 or YES to any of Q10-12 then you must tick Box B.

A. I consider that this project has **no** significant ethical implications to be brought before the University Research Ethics Committee.

State the purpose of the research. Give a brief description of participants and procedure (including the methods and tests used). This description must make clear what participants are expected to do. You must also make clear how data (e.g. video tapes) will be kept confidential and secure. Note that this description will be read by non-specialists and must be readily comprehensible by a lay person.

You must attach intended information and consent forms and copies of any questionnaires you plan to use. (see below)

B. I consider that this project may have ethical implications that should be brought before the Ethics Committee. **Yes**

Please provide all the further information listed below in a separate attachment. Note that this description will be read by non-specialists and must be readily comprehensible by a lay

person.

1. Title of project.
2. Purpose of project and its academic rationale.
3. Brief description of methods and measurements and how data will be stored.
4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria.
5. Consent and participant information arrangements, debriefing.
6. A clear statement of the ethical considerations raised by the project and how you intend to deal with them.
7. Estimated start date and duration of project.

I am familiar with the University of Dundee *Code of Practice for Research on Human Participants*, and have discussed them with the other researchers involved in the project. I confirm that my research abides by these guidelines.

Signed Print Name ELAINE LEE Date 11/12/06

(Lead Investigator)

There is an obligation on the lead researcher to bring to the attention of the Ethics Committee any issues with ethical implications not covered by the above checklist.

1. Title of project.

An exploration of lesbian women's experiences of disclosure of sexual orientation in pregnancy

Research question

- How do lesbian women experience disclosing or not disclosing sexual orientation to maternity care professionals in pregnancy?

Research Aims

- To identify the factors which lesbian women take into account when deciding whether or not to disclose sexual orientation in pregnancy
- To explore the perceived practical and psychosocial consequences for lesbian women as a result of the decision they make.

2. Purpose of project and its academic rationale.

This study is part of a PhD within the School of Nursing and Midwifery at the University of Dundee. The PhD student is a lecturer in midwifery with a particular interest in sociological aspects of midwifery, including the experiences of marginalised groups of women. The purpose of this study is to explore the experiences of lesbian women in relation to disclosure of sexual orientation. Approximately 10% of the population are gay men or lesbian women so a sizeable number of people accessing health care are gay. However, this client

groups is largely invisible because this form of minority status is not represented by visible attributes in the individual (Wilton and Kaufmann 2001). In maternity care there is a tendency to assume that if a woman is pregnant then she must be heterosexual. Because human reproduction depends on the joining of male and female DNA it is easy to assume this has been achieved through the sexual union of male and female. Maternity care is organised and delivered largely on this basis and this means that documentation, organisation and therapeutic approach are all 'heterocentric'.

A limited amount of empirical work has been undertaken into the experiences or needs of lesbian women in pregnancy. Wilton and Kaufmann (2001) remains the only significant research study undertaken within the UK. There is a growing body of literature that relates to the more general healthcare experiences of gay men and lesbian women, either as patients or employees (Taylor 1999; Ward and Winstanley 2005), but little research into the specific maternity care needs of lesbian women. Recent research in New Zealand (Neville and Henrickson 2006) has highlighted the importance of disclosure of sexual orientation in primary healthcare, concluding that nurses use gendered language and documentation which excludes those from lesbian, gay or bisexual client groups. Interestingly, the study concluded that statistically more women than men reported that their health care providers always presumed them to be heterosexual. So there is evidence that health care practitioners presume heterosexuality and the context

of health care might well have an impact on this. Where there is a pregnancy there is an additional signifier of heterosexuality.

The aim of this research is to explore lesbian women's experiences of pregnancy and maternity care, but more explicitly, their experiences of disclosing their sexual orientation to healthcare professionals when pregnant. The research is being undertaken to make an invisible group of women more visible in maternity care settings: to take the heterosexist assumptions of pregnancy and maternity care and to look at them from a different perspective. This different perspective is one that is hidden because the client group is frequently hidden (Salmon and Hall 1999). A long term research aim is to make explicit the experiences and needs of this group of women and so to influence maternity care in ways that help to meet these needs. However, the first steps must be taken in order to identify the key issues for lesbian women in terms of disclosure and to explore the extent to which these issues have a qualitative impact on the women's overall experiences of having a baby.

It is hoped that this study will enable lesbian women to talk in their own terms and to choose the aspects of disclosing sexual orientation that were important to them. As demonstrated in the literature review there is a substantial amount of research literature relating to coming out to know that the act of coming out has important psychological and experiential implications for gay men and women within healthcare and all other aspects of life (Taylor 1999; Markowe 2002; Gill,

Skelton et al. 2005). But this context is unique in that the process of pregnancy presumes heterosexuality and coming out is required for the lesbian who wants to be acknowledged as such.

3. Brief description of methods and measurements and how data will be stored.

This is a qualitative study whose primary data collection method is unstructured interviews using a storytelling technique. The aim of this approach is to reduce the assumptions within the study and to facilitate the voices of the women involved. The marginalised nature of the participant groups means that there is a power relationship between the researcher and the researched and there is an imperative to reduce this where possible. Providing an environment and data collection structure within which the participants directly control the information that is given promotes a more equal relationship within the study. It also allows the voices of the women to be heard in whatever way they feel is appropriate for them. It reduces the need for the participants to understand the nature of questions asked because the data is participant led.

It is anticipated that the interviews will be audio-taped and transcribed verbatim. The tapes will be kept in a locked filing cabinet and will not be accessed by anyone other than the researcher. The transcripts will be stored in accordance

with the Data Protection Act and will be coded. The researcher will be able to cross-reference the code with the participant data but the transcripts will be kept separately from the coding details. All demographic or identifying data will be stored on a university computer in password protected files. In accordance with the Data Protection principles, only data of relevance to the study will be recorded and no additional data or data not deemed appropriate will be kept. The data will not be used for any other purposes than those specifically related to the research study and will not be kept any longer than the period of the study. All participants will be informed that they have a right to see any data relating to them and to have this amended if appropriate.

Confidentiality will be the prime concern of the researcher given the sensitive nature of the research. The researcher is conscious of the potential issue of unintentionally 'outing' participants but the risk of this is considered very low, particularly in view of the sampling process (see below).

4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria.

The research will employ a non-probability sampling strategy in order to recruit those participants most likely to meet the aims of the research. The participants will be lesbian women who have been through at least one pregnancy. It is anticipated that women will be recruited using a combination of personal contacts within the LGBT community within the United Kingdom and a

snowballing technique. The snowballing technique will be employed to try to access women who did not disclose their sexual orientation to their care givers in their pregnancy. The purpose of the research is to explore experiences of disclosure and non-disclosure making it necessary for these two recruitment methods to be used.

As this is qualitative research the number of participants who will be recruited is as yet unknown. The likely number of participants will be approximately 20 but will be dependent on the number of women willing to participate. All participants will be over the age of 18 and will all be women. Apart from the lower age limit there will be no specific exclusion criteria as the participants will be purposively sampled and to some extent self-selected. A number of cautionary considerations have been identified such as length of time since the pregnancy, English as a second language and lesbian women whose experience of pregnancy was within a heterosexual marriage. Participation for these individual women will be negotiated and a decision about inclusion made on pragmatic grounds such as the woman's ability to recall the experience accurately or to understand and be understood in English.

5. Consent and participant information arrangements, debriefing.

Using a snowballing technique, potential participants will be identified and approached by other participants in the study. Any woman who is interested in participating will be sent an information sheet which gives them the background of the study and includes their right not to participate, their right to decline to answer particular questions, their right to withdraw from the study and their right to withdraw any data relating to them. Each woman will be offered the choice of where the interview will take place. It is hoped that by offering this option women will choose environments in which they feel safe and comfortable. A written consent form will be provided for each participant in the study. This will reiterate the rights stated above. Potential participants will be given a minimum of two weeks to decide whether or not to participate, during which time they may contact the researcher for clarification of any points raised.

There should be no requirement for debriefing as no deception will be used within the research and no information will be withheld at any time. All questions will be answered and the process will remain open and transparent at all times. All women will be offered the chance to read through their transcripts to ensure they are satisfied that they are not being misrepresented. This is less related to the process of participant validation than to promoting an equal power relationship between the researcher and the researched.

6. A clear statement of the ethical considerations raised by the project and how you intend to deal with them.

The issues of consent and confidentiality have been dealt with in sections 3 and 5 above.

The study participants are being selected by virtue of their sexual orientation and the fact that they have been through a pregnancy. It is possible, but not intended, that some of the potential participants would be pregnant at the time of the study. There are no interventions as part of this study and there will be no risk to the individual women or to the pregnancy. There is no intention to raise doubts in the minds of the women in relation to the care they received or are receiving in their pregnancy. The study is about their experiences of disclosure and their decision making processes in this regard and does not relate to the pregnancy per se. However, because of the possibility of raising such doubts or introducing concerns relating to the reactions of others in the rest of the pregnancy, women who are pregnant would not be included in the study population.

The other important ethical consideration in this study is the potential for accidentally 'outing' women who have not disclosed their sexual orientation or who are only partially 'out'. There is potential that being associated with the study would identify a woman as lesbian. However, this is only a theoretical risk as the participants will be approached through personal contacts and through lesbian mothers' support groups. They will not be approached in any

environment where their sexual orientation is assumed to be heterosexual. In addition to this, the research is a small scale study for a higher degree and is not high profile or widespread. I do not anticipate that this is going to be a practical issue but it is the obvious potential ethical problem in a study of this nature and must therefore be acknowledged. However, it is felt that the potential benefits to this under-researched group of participating in this research will outweigh the risks identified.

7. Estimated start date and duration of project.

The data collection will commence in early 2007. The PhD is being undertaken part-time within a 6 year time frame which will end in April 2011. However, it is hoped that the data collection process will not take longer than one year.

Appendix Two: PARTICIPANT INFORMATION SHEET

TITLE OF PROJECT: An exploration of lesbian women's experiences of disclosure of sexual orientation in pregnancy.

You are being asked to take part in a study exploring an aspect of disclosure of invisible factors of personal significance in pregnancy, specifically lesbian women's experiences of disclosing sexual orientation. I am a lecturer in midwifery within the University of Dundee, School of Nursing and Midwifery and this study is part of my PhD. The study is being supervised by Professor Julie Taylor, Research Dean and Dr Markus Themessl-Huber, a lecturer, both from the School.

PURPOSE OF THE STUDY: The purpose of this study is to identify the factors which influence lesbian women's decisions around disclosure of sexual orientation when pregnant. Because it is generally assumed that pregnant women are heterosexual, disclosure at this time may raise issues for lesbian women, particularly in relation to coming out to healthcare professionals. This study aims to explore this issue and to promote the development of safe environments for disclosure and increase the visibility of lesbian women in pregnancy.

TIME COMMITMENT: Data is being collected through an unstructured interview using a storytelling approach which is led by those taking part in the research. It is expected that most interviews will take up to an hour, and it is very unlikely that the whole process would take longer than 2 hours of your time. You may be asked at a later date to clarify some of the points identified in your interview, and it is expected that this would take no longer than 30 minutes.

RISKS: There are no known risks for you in participating in the research.

CONFIDENTIALITY AND ANONYMITY: All information you provide will remain confidential at all times and your data will be anonymised using pseudonyms or codes. Audio tapes and transcripts will be stored securely and locked away separately from personal and demographic information, in accordance with the Data Protection Act 1998. No publications as a result of the research will include identifiable personal information. You have a right to decline to answer any question and you have a right to withdraw your participation and your data from the research at any time.

FURTHER INFORMATION: If you would like any further information about the study at any time Elaine Lee will be pleased to answer your questions at any time. You may contact her at e.c.lee@dundee.ac.uk or telephone 01382 634302 ext 33618.

Elaine Lee

Lecturer/ PhD student

University of Dundee

School of Nursing and Midwifery

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The University Non-Clinical Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Appendix Three: Consent form

An exploration of lesbian women's experiences of disclosing sexual orientation in pregnancy

The purpose of this study is to identify the factors which influence lesbian women's decisions around disclosure of sexual orientation when pregnant. Because it is generally assumed that pregnant women are heterosexual, disclosure at this time may raise issues for lesbian women, particularly in relation to coming out to healthcare professionals. This study aims to explore this issue and to promote the development of safe environments for disclosure and increase the visibility of lesbian women in pregnancy.

Participation is entirely voluntary. Within the research your confidentiality will be protected at all times and you will have the right to withdraw from the study or decline to answer any question **at any time**. Such a decision will have no adverse consequences for you.

By signing below you are agreeing that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

Participant's signature

Date

Printed name of person obtaining consent
obtaining consent

Signature of person

Appendix Four: Wording from relevant assisted conception unit in relation to counselling prior to receiving donated gametes.

What may be discussed

We will need to take a detailed medical and social history of you and your partner. The issues that may be discussed are:

- * Your commitment to having and bringing up a child/children
- * Your ability to provide a stable and supportive environment for any child produced as a result of treatment.
- * Your medical histories and the medical histories of your families.
- * Your health and consequent future ability to look after or provide for a child's needs.
- * Your ages and likely future ability to look after or provide for a child's needs.
- * Your ability to meet the needs of any child or children who may be born as a result of treatment, including the implications of any possible multiple births.
- * Any risk of harm to the child or children who may be born, including the risk of inherited disorders or transmissible diseases, problems during pregnancy and of neglect or abuse.

- * The effect of a new baby or babies upon any existing child/children of your family.

In addition, if your treatment involves the use of donated gametes, the following will be discussed:

- * A child's potential need to know about their origins and whether or not you are prepared for the questions which may arise while the child is growing up.

- * The possible attitudes of other members of the family towards the child, and towards their status in your family.

- * The implications for the welfare of the child if the donor is personally known within the child's family and social circle.

- * An explanation of who will be the legal parents of any child produced as a result of treatment with donated gametes.